

~~DD5~~

~~43~~



22101789828

Presented by

J. W. St. Wadsworth

5th March 1912

PHYSICIANS' EDITION

PHOTOGRAPHIC ATLAS
OF THE
DISEASES OF THE SKIN
IN FOUR VOLUMES

*A Series of Ninety-six Plates, Comprising nearly Two Hundred
Illustrations, with Descriptive Text, and a Treatise
on Cutaneous Therapeutics*

BY

GEORGE HENRY FOX, A.M., M.D.

PROFESSOR OF DERMATOLOGY, COLLEGE OF PHYSICIANS AND SURGEONS, N. Y.
CONSULTING DERMATOLOGIST TO THE DEPARTMENT OF HEALTH, NEW YORK CITY
PHYSICIAN TO THE NEW YORK SKIN AND CANCER HOSPITAL
ETC.

VOL. II.

PHILADELPHIA AND LONDON
J. B. LIPPINCOTT COMPANY



Copyright, 1900, by GEORGE HENRY FOX

Copyright, 1901, by GEORGE HENRY FOX

Copyright, 1902, by GEORGE HENRY FOX

Copyright, 1905, by GEORGE HENRY FOX

WELLCOME INSTITUTE LIBRARY	
Coll.	welMOMec
Call	+
No.	WR17
	1905
	F79 p
	179

CONTENTS

VOLUME II.

	PAGE
DERMATITIS HERPETIFORMIS	65
ECZEMA	67
ELEPHANTIASIS	79
EPITHELIOMA	80
ERYSIPELAS	85
ERYTHEMA	87
ERYTHEMA MULTIFORME	89
FAVUS	91
FIBROMA	93
FURUNCULUS	95
HERPES	99
HYPERIDROSIS	101
HYPERTRICHOSIS	107
ICHTHYOSIS	111
IMPETIGO CONTAGIOSA	113
KELOID	114
KERATOSIS FOLLICULARIS	118
LENTIGO	119



Digitized by the Internet Archive
in 2019 with funding from
Wellcome Library

https://archive.org/details/b31360257_0002

LIST OF ILLUSTRATIONS

VOLUME II.

- Plate XXV. Elephantiasis
- Plate XXVI. Epithelioma
- Plate XXVI. Epithelioma
- Plate XXVI. Epithelioma
- Plate XXVI. Epithelioma
- Plate XXVII. Epithelioma rodens
- Plate XXVIII. Erysipelas
- Plate XXIX. Erythema papulatum
- Plate XXX. Erythema annulatum
- Plate XXXI. Erythema bullosum
- Plate XXXII. Erythema multiforme
- Plate XXXII. Erythema multiforme
- Plate XXXII. Erythema multiforme
- Plate XXXII. Erythema multiforme
- Plate XXXIII. Favus
- Plate XXXIII. Favus
- Plate XXXIV. Fibroma
- Plate XXXIV. Fibroma
- Plate XXXV. Herpes faciei

LIST OF ILLUSTRATIONS

- Plate XXXVI. Ichthyosis
- Plate XXXVII. Impetigo contagiosa
- Plate XXXVIII. Keloid
- Plate XXXVIII. Keloid
- Plate XXXIX. Keratosis diffusa
- Plate XXXIX. Keratosis follicularis
- Plate XL. Lepra
- Plate XLI. Lichen planus
- Plate XLI. Lichen planus
- Plate XLII. Lichen planus hypertrophicus
- Plate XLIII. Lichen ruber papulosus
- Plate XLIV. Lichen ruber squamosus
- Plate XLV. Lupus erythematosus
- Plate XLVI. Lupus vulgaris
- Plate XLVII. Lupus serpiginosus
- Plate XLVIII. Lupus exedens

DERMATITIS HERPETIFORMIS

DERMATITIS herpetiformis is a chronic, relapsing, neurotic affection characterized by the eruption of erythematous patches, papules, pustules, vesicles, and bullæ. The lesions usually show a marked tendency to appear in groups and are accompanied by a pruritus that is often extremely severe. The eruption may be limited to the face and arms, to the trunk, or to some other region, but in severe cases the whole body is usually affected. The disease presents various types, according to the character of the lesions. The most frequent is that in which a few vesicles occur in a group, though by no means so closely aggregated as in ordinary herpes. The lesions, when not excoriated, dry and present a puckered aspect. They run an acute course, but the eruption is continued by the constant appearance of new lesions. Often the disease subsides for a few weeks or months, and the skin becomes comparatively or quite normal in appearance, but a relapse may be anticipated, and the disease is liable to persist for many years if not successfully treated.

The differential diagnosis between this disease and certain others is not always easy to make, and many cases of pemphigus and erythema multiforme are apt to be claimed as examples of the bullous or erythematous form.

The etiology of the disease is obscure in most cases, but clinical observation leads to the belief that the cutaneous lesions are but reflex manifestations of some disease of the nervous system. Fright, worry, and nervous shocks have preceded the eruption in several reported cases, while glycosuria and polyuria have been noted as coexistent in others. In pregnancy the eruption is liable to occur, and repeated attacks in successive pregnancies have been reported, the patients being freed from the eruption soon after delivery.

The treatment of dermatitis herpetiformis is usually unsatisfactory. The cause is difficult to discover in the great majority of cases, and while improvement may take place under treatment, as it often does spontaneously, relapses may be confidently expected. There are few cutaneous diseases of an inflammatory nature which are more rebellious to treatment, and a cure should be hoped for rather than predicated.

A strict inquiry into the life and habits of the patient, with an examination of the urine, should be the first step in treating every case. If anything is discovered that might be justly deemed an etiological factor, it should receive attention and be rectified if possible. Hygienic treatment of the patient is likely to do far more good than pharmacopœial remedies. Overwork and mental anxiety frequently intensify, if they do not cause, the eruption, and in such a case a short vacation, with its concomitant change of both mental and physical habits, is almost certain to be of great benefit.

Arsenic may control or check the eruption in some cases of the vesicular or bullous type, acting as it often does in pemphigus; but as a rule this drug should not be relied upon, and when it is not well tolerated by the stomach, an increase of the dose is certain to do more harm than good. Winfield praises cannabis indica as one of the most valuable sedatives. The fluid extract may be given in doses of two or three drops every three or four hours, according to the indications.

Antipyrin and phenacetin have been used with good effect, and the concentrated tincture of *avena sativa* in twenty-drop doses may relieve the nervous condition which frequently complicates each outbreak of the eruption.

The local treatment should vary according to the character of the lesions. Lotions are best adapted to the erythematous type, while a sulphur or salicylic ointment may be serviceable in the papular or excoriated type of the disease. When the itching is intense a strong carbolic acid lotion (fifteen to twenty per cent.) or a mixture of camphor and chloral in oil (one to five per cent.) may give considerable relief. General galvanism, recommended by Stelwagon, is one of the most effective anti-pruritics, and may be used to advantage in this as in other pruriginous affections of neurotic origin.

ECZEMA

The treatment of eczema furnishes an excellent test of a physician's skill and experience. Owing to the variety of conditions under which it appears, scarcely two cases can be treated alike and with equal success. While in many cases an injudicious treatment does more harm than good, and actually keeps up the disease, in other cases a most surprising and gratifying result may be obtained by the employment of some simple but effective measures. It can readily be understood, therefore, that a knowledge of a few principles which govern the treatment of eczema is worth a whole volume of formulæ.

Eczema is never an incurable disease. It is often extremely obstinate, and there are cases in which the physician must acknowledge his inability to effect a cure under the existing circumstances. But if the patient can be properly controlled, his diet carefully regulated, his mind put at ease, etc., it will then be found that simple treatment will usually accomplish a speedy cure. Eczema is far more amenable to treatment than most other skin diseases, but the causes of the eruption must be recognized and removed, before local applications can be expected to have much beneficial effect.

In nearly all cases, eczema is of internal origin, and even when it is manifestly evoked by some external agent acting directly upon the skin, there is always a disposition or tendency to the disease which is characteristic of the individual.

The danger of rapidly curing an eczema or a leg ulcer is an ancient myth. It seems to have died repeatedly, but has never been effectually buried. Recent writers have partially resuscitated it by reports of cases of convulsions and broncho-pneumonia following a rapid cure of the disease. The rarity of such sequelæ would naturally suggest that they had no more to do with the eczema than falling downstairs or any other accident or disease. Duhring ("Cutaneous Medicine") tells of an anæmic woman with

a pustular eczema of the scalp which resisted several months of treatment. She suddenly contracted pneumonia and died, the eczema having rapidly disappeared with the advent of the pneumonia. That any metastasis occurred in this case is wholly without proof, and in the light of clinical experience seems quite improbable. In infancy, an eczema of scalp or face usually disappears with the occurrence of any acute inflammation of the lungs or brain, which seems to have a revulsive effect. An eczematous eruption may be *drawn in* by an internal congestive disease, but it can never be *driven in* by any external treatment. I agree with the majority of writers that no harm can result from curing an eczema, and that the general well being is promoted by removing a constant source of local and general irritation.

The internal or medicinal treatment of eczema usually has little direct effect upon the eruption, but much can be accomplished indirectly through the use of laxatives, bitter tonics, and diuretics. In every case of eczema the bowels must be kept freely open. While continued purgation tends to weaken the patient, and is inadvisable, an occasional dose of calomel at night, followed by some mineral water in the morning, will prove of great benefit. Rhubarb and soda, cascara, or a pill of aloin, belladonna and strychnia may be given daily as a prophylactic against constipation. When the tongue is heavily coated and the stomach foul, a dietary restricted to one or two articles of food should be rigidly enforced, and a tablet containing salol, sodium sulphite, or resorcin, given between meals, with a view to disinfecting the intestinal canal as far as possible.

The fluid extracts of various vegetable substances other than those which have a laxative effect may be used to advantage in cases of chronic eczema. Among them may be mentioned cinchona, gentian, stillingia, taraxacum, rumex, etc. They often increase the appetite and improve the digestion through their action on the hepatic and other intestinal secretions, and produce, in short, what the older writers termed an alterative effect. Though capable of doing some good in many cases, they are by no means to be regarded as "a remedy for eczema," and too much dependence should not be placed upon their therapeutic value.

The alkaline diuretics, such as the acetate or citrate of potash and the salts of lithia, are of decided value in all cases where there is a notable degree of cutaneous congestion. They should be taken, well diluted, a short time before meals, and with the increased action of the kidneys, a marked decrease of the redness and burning sensation of the skin will frequently be noted.

Arsenic is a remedy which has been greatly abused in the treatment of eczema and other skin diseases. It is one with a double edge, and apt, in many cases, to do harm rather than good, impairing the digestion and aggravating the eruption. Considering its routine prescription by so many physicians, it would seem almost advisable to condemn its use entirely, but there are some chronic cases of localized eczema, characterized by thickening and scaling rather than by acute congestion, in which arsenic may be employed to advantage.

As regards antimony, calcium chloride, viola tricolor, and other internal remedies which have been considered by some to have an especially beneficial effect in eczema, it can only be said that in most cases a reliance upon them leads only to disappointment.

In the local treatment of eczema a host of remedies has been recommended and frequently employed with no definite idea of what they are expected to accomplish. A change is usually made from one to another if the case does not progress favorably, and undeserved credit is often given to some local remedy when a cure is effected. While much can be accomplished in most cases of eczema by appropriate local treatment, the idea is too prevalent that certain drugs or formulæ have a special and wonderful effect. Failure often results from undue reliance upon the therapeutic action of local applications, to the neglect of general measures which tend to improve the condition of the patient and thereby remove the cause of the eruption. A few remedies, with a knowledge of what they are capable of doing, are worth pages of formulæ which promise far more than they ever fulfil.

Local remedies in the treatment of eczema may be roughly divided into two classes, viz., those which soothe and those which stimulate. At

the outset, in every case, the physician must determine whether the conditions present are such as demand a soothing or a stimulating plan of treatment. If the eruption be acute and irritable, the application selected cannot possibly be too bland ; while, on the other hand, if the eruption be chronic and characterized by much thickening of the skin, a soothing ointment or lotion is of no use, and something that will quicken the circulation of blood through, and improve the nutrition of, the tissues is what is plainly demanded.

Among the soothing applications the oxide of zinc—in powder, lotion, ointment, or paste—has long been used and never excelled. In mild erythematous eczema or the intertrigo of children the powder, mixed with equal parts of starch or talcum, will be found both effective and agreeable. In all cases of superficial eczema attended by marked congestion and an intense burning sensation a zinc lotion is the most soothing application which can be made. The simplest plan of using this is to add one part of oxide of zinc powder to three or four parts of lime water, and apply frequently to the affected skin by means of a soft rag or tuft of cotton. As the zinc is insoluble, the mixture must of necessity be well shaken before each application. Calamine is often added to the zinc to render the deposit upon the skin less white and conspicuous, and a little carbolic acid is also added to the mixture for its supposable anti-pruritic effect, but the plain zinc and lime water is quite as serviceable. Here is a formula of the zinc and calamine lotion in common use :

℞	Zinci oxidi	℥ ss	10
	Calaminæ	℥ iv	2
	Acidi carbolicæ	f ℥ ss	2
	Glycerini	f ℥ i	10
	Liquoris calcis	ad f ℥ vi ad 100	

℥

Sig.—Shake well before using.

In acute exuding eczema the oxide of zinc ointment of the pharmacopœia or any similar bland ointment may be spread thickly on pieces of stout muslin and bound smoothly over the eruption. Zinc ointment was

most highly recommended by Erasmus Wilson, the celebrated English dermatologist of a past generation, and it is equally valuable to-day in spite of the innumerable substitutes which are in common use. Many physicians seem to regard it as too old-fashioned, or perhaps too simple for them to prescribe, and so they add a little carbolic acid or a little resorcin, or something else which tends to convert it from a soothing into an irritating application, and thereby defeat the object of its use. If every physician were compelled by law to use plain zinc ointment in the local treatment of acute eczema many would find that their efforts to cure would be crowned with far greater success than at present. Now, after this encomium, I might add that I seldom use zinc ointment myself. All ointments are apt to be more or less disagreeable to patients, and should only be prescribed when it is absolutely necessary to do so—i. e., in about one-tenth of the cases in which they are commonly prescribed.

In many cases of eczema a zinc paste or an ointment that will dry upon the skin is much preferable to a soft, greasy application. Upon the face and hands it needs no muslin. Upon the covered parts, the paste may be smeared over the eruption and covered with pieces of cheesecloth, which will stick like a plaster and prevent the rubbing off of the paste upon the clothing. The following is the formula of a paste now in general use :

℞	Acidi salicylici	gr. x	2
	Zinci oxidi	℥ ii	25
	Pulveris amyli	℥ ii	25
	Vaselini	ad ℥ i	ad 100
℥	(LASSAR)		

A similar paste suggested by me many years ago is mentioned by Hardaway as still more acceptable :

℞	Acidi salicylici	2
	Bismuthi subnitratis	30
	Amyli maidis	20
	Unguenti aquæ rosæ	ad 100
℥		

The use of gelatin as an impervious coating has given satisfactory results in many cases. The following formula may be employed and the ingredients varied according to the consistency desired; if more gelatin is used the application will be softer, but slower in drying:

℞	Zinci oxidi	15
	Gelatini	25
	Glycerini	30
	Aquæ	ad 100

℥

Melt and apply every four days.

In my service at the Vanderbilt Clinic, Dr. Dade has treated many cases of eczema during the past five years by means of such a varnish, and has found it of especial service in eczema of the flexures of the joints, where other dressings are difficult to apply. In chronic scaly patches it is advisable to first rub the skin with the oil of cade and then apply the hot glyco-gelatin varnish, covering it with a bandage when dry. The itching is generally allayed by the exclusion of air and the constant pressure exerted.

Among the stimulating applications of service in treating chronic eczema may be mentioned tar, sulphur, resorcin, salicylic acid, and chrysarobin. On account of the deeper effect desired in treating an eczema with more or less thickening of the skin, these substances are best used in the form of an ointment, and wool-fat (*adepts lanæ hydrosus*), on account of its ready absorption by the skin, constitutes the most desirable ointment base.

Tar, in spite of its objectionable odor and color, is one of the oldest and most effective cutaneous stimulants. It has a decided anti-pruritic effect, and in subacute cases, characterized by dryness and slight scaling, it is extremely beneficial in restoring the diseased skin to its normal condition. Among the various forms in which tar is used, the oil of cade seems to me to be the most desirable. The following ointment may be used to great advantage in many cases of eczema as soon as the acute stage has subsided:

℞ Olei cadini 10
 Unguenti zinci ad 100
 ℥

In recent years ichthyol has become extremely popular as a substitute for tar, and thiol in less degree. The former is far more objectionable than tar so far as odor is concerned, and, in spite of the enthusiastic praise of its therapeutic efficacy by some of my colleagues, I find no occasion, after careful tests of its value, to use it in my practice.

Sulphur and resorcin are often productive of good results in cases of superficial squamous eczema, although they have been known to fail. In cases where there are thick, horny scales, as in eczema of the palms and soles, salicylic acid is a most reliable remedy, accomplishing results which could be obtained through no other agency. Chrysarobin has a much deeper action and is indicated in case of obstinate circumscribed patches.

Frictions with green soap were formerly much in vogue in the treatment of chronic eczema, and may be of service when crusts and scales are to be removed. In acute eczema soap and water are always objectionable on account of their irritating effect, but in chronic eczema soap frictions can certainly do no harm. When dry, indurated patches of long standing are present, Spiegler recommends painting the skin for a minute or less with equal parts of caustic potash and water and then applying a fifty per cent. solution of nitrate of silver.

The use of vulcanized rubber sheeting in the treatment of eczema has never attained the popularity in this country which its simplicity and effectiveness would seem to warrant, and since the time of Hebra it seems to have become almost obsolete. As regards this method of treatment, I venture to say that if some of my esteemed medical brethren would lay aside for a while their prescription pads and simply use rubber cloth in the local treatment of most cases of eczema, whether acute or chronic, they would be amazed at the unexpected and gratifying results. The pieces of rubber cloth should be of the heavy grade, applied smoothly, with the rubber side next to the affected skin, and changed at frequent intervals.

Since eczema occurring upon different parts of the body presents certain peculiarities which call for a special method of treatment, it is advisable to consider a few of these regional varieties separately, and to briefly indicate their therapeutic requirements.

Eczema of the head requires a varied treatment, according to the age of the patient, the chronicity of the disease, the length of the hair, etc. While in infants and men with short hair an ointment can often be used to advantage, in most cases of eczema capitis an oily lotion is preferable. In dry, squamous eczema of the scalp, a mixture of one part oil of cade with two or more parts of almond oil may be rubbed in thoroughly every night and the head shampooed once or twice a week. In the pustular or exuding variety of the disease, thick crusts are apt to form which can be most speedily and comfortably removed by having the patient wear a vulcanized rubber skull cap for one or two nights. A soothing lotion or soft ointment may then be carefully applied, and, as the exudation ceases, a slight addition of tar, resorcin, or salicylic acid will often be found to hasten the cure.

In children, an occipital eczema should always lead one to suspect the presence of pediculi. The sulphur or ammoniated mercury ointment necessary to destroy them may sometimes produce a temporary aggravation of the eczema, but the latter will be found difficult to cure so long as the pediculi remain and occasion a continual pruritus. The hair of children, especially in summer, may be closely cut to facilitate the treatment of eczema, but in the case of girls and women the cutting of long hair should never be advised, although its presence may involve extra labor in the application of local remedies.

Eczema of the ears is usually associated with eczema capitis, but may occur alone and affect either the auricle and surrounding parts or the external auditory canal. If the disease is acute, a zinc lotion is beneficial; but if there is much thickening of the auricle a stimulating ointment or paste is called for. For the scaly condition of the auditory canal, which is frequently accompanied by an annoying pruritus, a weak solution of nitrate

of silver—or, better still, the oil of cade, either pure or diluted—may be applied frequently by means of a swab. The daily syringing of the ear is very apt to interfere with a cure.

Eczema of the nostrils may be treated like eczema of the auditory canal. In some cases, however, the inflammation is very acute, and the crusts, which form rapidly and block the passages, must be first removed by the application of a bland oil or some very soft and soothing ointment, like the following :

℞	Adipis lanæ hydrosi	3
	Adipis porci	6
	Liquoris calcis	ad 20

℥

Eczema of the beard sometimes occurs in an acute form, and resembles sycosis, since pustulation may take place around the hair follicles. There is usually considerable swelling and surface exudation, and while a soothing lotion or paste is applied externally, the bowels must be freely opened and the general health of the patient improved in every possible way before the eruption will yield. Upon the upper lip the disease is often secondary to a chronic nasal discharge which requires treatment more than the resulting eczema beneath the nostril. In the dry, squamous form of eczema of the beard, with more or less thickening, soap frictions and a stimulating ointment are indicated. The following paste may be found of service :

℞	Acidi tannici	3 i	10
	Sulphuris præcipitati	3 ii	15
	Zinci oxidi		20
	Amyli	āā gr. cl	20
	Petrolati mollis	gr. clx ad	100

℥

(ROSENTHAL)

Eczema of the genital regions is not very common, but when it does occur is apt to be extremely annoying. The penis and scrotum, and espe-

cially the latter, may present an acute, moist eruption, for which a zinc lotion is applicable. But soon this condition disappears, and a thickened skin is left, with a dry, harsh, or excoriated surface and a marked deepening of the natural furrows. For this condition, the soothing applications may afford temporary relief from the pain and itching. But more severe treatment is necessary to restore the skin to its normal state. I have found chrysarobin, when cautiously used, to be of the greatest service in these cases of chronic scrotal eczema. A mild ointment should be tried at first. A strong ointment is apt to give considerable pain for a half-hour, but I have known this to be followed by the first good night's rest that the patient had enjoyed for many months.

For an acute eczema of the female genitals, attended by great pain and swelling, the application of very hot cloths will often give immediate relief when many kinds of ointments and lotions have been used with absolutely no effect. For chronic eczema of the labia, with infiltration and annoying pruritus, a strong galvanic current has, in numerous instances in my experience, afforded the greatest relief and done much toward effecting a cure.

Eczema of the anus and perinæum constitutes one of the most annoying forms of the disease, the patient not only being robbed of much of his night's rest, but rendered most uncomfortable at times during the day. The pruritus is often so intense that the sufferer must hastily retire from company, or perhaps indulge in a little clandestine scratching regardless of appearances. This form of eczema occurs in nervous individuals, and is essentially symptomatic. Frequently there is but little thickening of the skin and few excoriations, and a hasty examination of the part would hardly show any cutaneous disease. In other cases of long standing there will be found much infiltration with fissures and considerable scaling or crusting.

In treating this variety of eczema local measures are chiefly palliative and the general health of the patient must be improved in every possible way. A sea voyage or vacation of some length will often do much good. When this is not feasible, the daily work hours should be shortened, and all sources of worry and mental anxiety removed if possible.

The bowels should be kept freely open by small doses of calomel and phosphate of soda or mineral water, taken every morning. When hemorrhoids are present, an operation for their removal should be performed without delay.

The diet must be restricted to simple nutritious articles of food, and any peculiar dietetic habits carefully considered. I have known several cases to be greatly benefited by abstention from tobacco, and others in which an excessive use of coffee seemed to increase the pruritus.

Locally, a strong carbolic lotion may be employed if the skin is not excoriated, or a soothing ointment applied if there are inflammatory symptoms. To lessen the chronic thickening of the skin nothing is better than a chrysarobin ointment or varnish.

Eczema of the hands and feet usually requires a special method of treatment, owing to the thickness of the epidermis upon the palms and soles, and the peculiar conditions which result. The palms are more frequently affected than the soles. They may present a swollen appearance, with a few vesico-pustules or moist, crusted patches, a diffused, scaly aspect, with painful cuts or fissures, or, at a later stage, the whole surface may be comparatively smooth, reddened, and cross-lined by the natural furrows of the skin.

A scaly patch upon the palm often presents an appearance so closely resembling syphilis that even an expert is unable to determine its character solely from its clinical aspect. As in such a case a correct diagnosis is the basis of successful treatment, it is well to bear in mind the fact, which is rarely mentioned in any text-book, that eczema of the palms is almost invariably symmetrical, while the squamous syphiloderm is very apt to be found only on one palm.

For eczema of the hands the brown rubber gloves used by surgeons will often do more good than any local application. They should be sufficiently large to be drawn on and off without risk of tearing, and worn for a short time both day and night. It is advisable to have two pairs, so that a frequent change can be made in order to keep them clean and comparatively odorless.

The maceration of the skin softens the dry, horny epidermis, removes all crusts, heals the painful fissures, and quickly imparts to stiffened fingers a notable increase of flexibility.

Eczema of the feet may be treated in a somewhat similar manner by means of vulcanized rubber sheeting. One piece cut to fit the sole and other small pieces made to cover eczematous patches upon the dorsum of the foot can be kept in position (the rubber side next to the skin) by means of a tight stocking.

Eczema of the legs, with or without ulceration, is of frequent occurrence, and may persist for many years if not properly managed. The lower third is usually its seat, and, whether the surface be dry or moist, there develops in time a decided thickening of the skin, which calls for vigorous local measures. The application of a soothing ointment may please the patient by affording slight temporary relief from pain or itching, but it will never effect a cure. Rest in bed is advisable if there is much swelling; but when the patient is obliged to continue work and be for many hours daily on the feet, a carefully applied bandage is the next best thing in the way of prophylaxis.

When there is a dry, scaling surface, an ointment containing oil of cade or salicylic acid—or, better still, chrysarobin—may be rubbed into the patches night and morning or applied on strips of cloth beneath a bandage. When an exuding surface is present the application must not be too stimulating at first, and in very many cases of eczema of the leg the application of strips of thick vulcanized rubber cloth will be found simpler and more effective than any ointment. When there is much infiltration of the leg, with more or less crusting, the rubber bandage is an ideal method of treatment, as it macerates the surface, favors exudation, and quickly reduces the swelling through the equable pressure which it exerts. Often the circumference of an eczematous leg will be lessened several inches in a few days. When the skin is irritable, and especially in hot weather, the bandage will sometimes cause the eczema to spread, and must be discontinued in such a case.

ELEPHANTIASIS

THE cause of elephantiasis is uncertain. It is neither contagious nor hereditary, and usually occurs in middle life. The dark-skinned races, and particularly those living in malarial regions near the seacoast, seem most liable to be attacked by the disease. Like leprosy, it has been ascribed to a fish diet, but without convincing proof of this origin.

In the treatment of elephantiasis much can be done in the early stage to relieve the inflammatory symptoms. Rest in bed, elevation of the limb, and the application of antiphlogistic lotions are plainly indicated during the acute exacerbations.

But cases are rarely seen in this country until the characteristic hypertrophy has developed through repeated erysipelatous attacks. For this condition the rubber bandage may be advantageously used when leg or arm is affected. A speedy, though perhaps not permanent, diminution in the size of the limb can often be effected. From nerve stretching, and from the persistent use of a strong galvanic current, good results have been reported. The ligature of the large artery supplying an elephantiasic part has often been performed, but no brilliant result has seemed to follow this procedure. When the scrotum or leg has enlarged to such a degree as to impede locomotion, amputation is advisable.

The early removal of a patient from the country where the disease is endemic is generally followed by an improvement and sometimes a cure. When the hypertrophy is great, the inflammatory exacerbations sometimes continue to recur in spite of a change of residence. As in leprosy, the change of climate is the first and perhaps the most important point to consider in the way of treatment.

EPITHELIOMA

Epithelioma is a malignant disease involving the skin or mucous membrane, and characterized by a downward growth of epithelial cells into tissues where they do not normally exist. These occasion an inflammatory process, which, sooner or later, leads to ulceration and considerable destruction of tissue.

Three clinical forms of the disease are commonly described. The first, or superficial form, begins usually as a pale, waxy nodule of the size of a split pea, and most frequently seated upon the upper portion of the face. Sometimes an aggregation of several of these small nodules occurs, and a firm undulating tumor is formed, which has been aptly compared, in appearance, to the crown of a molar tooth. The central portion of this tumor becomes crusted in time, and finally a shallow, glazed ulcer with an indurated border is formed. Not infrequently the disease begins as a small and persistent abrasion, or as a roughened patch, which after a few years' duration tends to crust formation, and finally develops the same characteristic ulcer. This often cicatrizes in the centre as it extends at the periphery, and, in the course of five, ten, or fifteen years, involves a considerable extent of skin by means of this slow, serpiginous growth. The term rodent ulcer has long been applied to this superficial variety of the disease. Some claim that the two affections are pathologically distinct though nearly identical in clinical appearance.

The second, or deep-seated, form of the disease may develop from the superficial variety, or begin as a firm, flattened tumor of the skin with a central depression. This gradually becomes the seat of an ulcer with an uneven, readily bleeding surface, and with an indurated and everted border. This form is attended from the outset by considerable pain, and as the disease progresses the suffering increases. The infiltration of the healthy skin goes on steadily if the disease is not properly treated. Sooner or later the lymphatic glands of the region become involved and gradual exhaustion precedes the fatal termination.

The third, or papillomatous, form presents the appearance of a warty excrescence at the outset, rapidly ulcerates, and pursues the course already described.

The cause of epithelioma is beyond our present knowledge. Continued irritation of the skin will not alone suffice to produce it, although it may frequently determine its location in certain cases. Lewis mentions an epithelioma developing on the side of the nose at the point where the eyeglasses rested for many years. This may or may not have been an etiological factor. I have seen so many cases of superficial epithelioma develop upon the side of the nose a short distance from the point so often reddened and depressed by the constant pressure of eyeglasses, that the local irritation seems to have little or nothing to do with the origin of the growth. An epithelioma of the lip is frequently attributed, and perhaps justly, to the frequent use of a pipe ; but it is also a fact that the disease often occurs upon the lip in the case of men who do not use tobacco in any form. It frequently develops upon the site of a mole, cutaneous horn, or some papillomatous degeneration of the skin such as is quite common in advanced life. No proof of its hereditary nature can be adduced from the fact that it occasionally develops in successive generations.

The disease is one which never gets well spontaneously, and its prognosis depends entirely upon the location, stage, and extent of the growth. Its malignancy varies greatly, and while in many cases the growth may remain for many years with very slight or no perceptible increase, in other cases, and particularly those of the deep-seated variety, it tends to spread rapidly at times, and if not vigorously treated soon gets beyond the reach of surgical measures. The prognosis is more unfavorable when the disease attacks the mucous membrane, and when its situation renders its complete removal a difficult task.

In the treatment of epithelioma mild measures are likely to do more harm than good. Many lives have been sacrificed to that fear of the knife which is quite natural to most patients, and which has led many to avoid radical treatment, in the vain hope that some more agreeable treatment would suffice to

effect a cure. No one can blame a patient for this instinctive dread of an operation which does not seem to him to be absolutely necessary, but no words of condemnation can be too strong for the physician who encourages the erroneous belief that some mild application may take the place of vigorous surgical treatment. Even the charlatans who trade upon the willingness of their victims to submit to the torture produced by some violent escharotic, rather than undergo a painless operation by a skilful surgeon, are often successful in effecting a cure, and cannot be justly accused of a do-nothing plan of treatment. Too often a physician with little or no experience will putter or experiment with a small epithelioma until it gradually grows larger and deeper, and becomes much more difficult to cure. Too often both physician and patient are deceived by an apparent improvement in the superficial aspect of the growth, while all the time the disease is infiltrating the deeper tissues and steadily tending toward that point of progress where it becomes evident to all concerned that further delay must be extremely dangerous.

Every physician who undertakes the treatment of an epithelioma assumes a grave responsibility, and if he allows the disease to progress from month to month or from year to year, he is guilty in many cases of a flagrant malpractice. There are unfortunately some cases of neglected epithelioma which are incurable, and for every case of this description there are often from one to a half-dozen physicians upon whom the patient has relied for proper advice, if not for treatment, and to whose ignorance or neglect the final death of the patient is directly due.

Epithelioma is a local disease, and the main object of treatment should be to completely remove the growth before it has produced irreparable injury. It may be cut out, scraped out, bored out, or burned out, but it must in some way be thoroughly destroyed. When the lip or tongue is involved or when the infiltration of the skin is extensive and deep, and neighboring lymphatic glands are involved, nothing can take the place of the knife in the hands of an expert surgeon. In most cases, however, the disease is quite superficial at the outset, and it is largely a question of choice whether it shall be destroyed by means of curette or a caustic, or by a combination of both.

Of the many chemical caustics which have been used in the treatment of epithelioma, arsenic stands first, and can best be used in the form of a paste, first recommended by Marsden. This is composed of two parts of arsenous acid and one of powdered acacia, mixed with a sufficient quantity of water. While caustic potassa, chloride of zinc, and the acid nitrate of mercury are not only painful, but tend to destroy healthy as well as morbid tissue, arsenic exerts a selective action, and will remove a superficial epithelioma without injury to the surrounding healthy skin. The strength of the paste can be varied, and cocaine combined with it to lessen intense pain. Applied on a piece of stout muslin no larger than a quarter of a dollar, it may be allowed to remain for several hours or several days, according to the effect desired and the ability of the patient to endure pain. Bougard's paste, which is a mixture of various caustics, has the advantage, it is claimed, of being less painful than the plain arsenical paste, and less apt to do harm when applied to a large surface.

Kaposi speaks highly of a pyrogallic ointment of from ten to twenty per cent. strength, remarking that it destroys only the diseased tissue, and is painless in its action. For several years I used this ointment, applying it freely to the raw surface after curetting. It occasions considerable pain when first applied, but this ceases entirely after an hour or two. It promotes free suppuration, and undoubtedly tends to destroy any superficial remnants of the morbid growth, but it has by no means the efficacy of arsenic, and after thorough curetting, using first a large and then a slender curette or burr, I much prefer to bore into the raw surface with a cone of nitrate of silver.

The use of the curette is condemned by many writers on account of its failure to destroy all of the diseased cells, and the consequent probability of the return of the disease. A superficial erosion, it is true, does little good, and may, indeed, be productive of harm. Like repeated cauterization with nitrate of silver and other mild measures, it may tend to stimulate the growth by increasing the cell proliferation and invasion of tissue. But if a curette is vigorously used, a small epithelioma can often be very quickly and, after an injection of cocaine, painlessly destroyed by means of this instrument alone. It is advisable, however, after removing the mass of morbid tissue, which is always much

softer than the normal skin, to treat the raw surface with a view to destroying minute foci of disease which escape the action of the curette. Little crypts or prolongations of the disease often remain after curetting, and may be discovered and destroyed by means of a dental burr dipped in carbolic acid, or a sharp cone of nitrate of silver firmly pressed into them. Even in cases where the arsenical paste is to be used, it is advisable to first remove the mass of soft tissue with the curette, and thereby lessen the time required for the paste to do its destructive work. The raw surface produced by the use of a curette or left after the removal of a slough may be covered with a small piece of mercurial plaster. This makes the simplest dressing, and beneath it granulation will proceed rapidly and the smoothest cicatrix result.

The use of the actual or galvanic cautery in the treatment of epithelioma is to be condemned, since it must necessarily destroy much healthy tissue or fail to destroy all of the morbid growth. In the use of the curette or burr the sense of touch is far more important than that of sight, and usually reveals the direction in which the disease is tending to spread. By the vigorous use of the latter instrument the morbid tissue can be mostly destroyed in an ordinary case of epithelioma as readily as a dentist digs out the soft carious substance from a dental cavity, and the inflammation resulting often suffices to destroy the cells which are not reached by the steel.

The latest method of treating epithelioma is by radiotherapy, or the use of the X-ray. This method is as yet in its infancy, and no definite statement of its value or demerits can be made at the present time. Cases of superficial epithelioma are reported as cured after many daily sittings, and it is certain that such cases might have been successfully curetted or destroyed by an arsenical paste and much time and trouble saved. Other cases have been prematurely reported by enthusiastic experimenters, in which improvement is claimed to have taken place and in which a cure is expected to follow. Many other cases in which the new treatment has possibly failed or even done harm have not been reported at all. But, nevertheless, the brilliant results which have been achieved in some cases lead to the hope that radiotherapy is destined to become a most important therapeutic agent.

ERYSIPELAS

Erysipelas is a disease which varies greatly in its severity. It may run its course in a few days in one case and last a few weeks in the next. This uncertainty of duration makes it difficult to estimate the value of remedial treatment in most cases, and has doubtless led many to overestimate the value of certain methods of treatment, and to depreciate the influence exercised by the *vis medicatrix*.

Among the internal remedies given in erysipelas the tincture of the chloride of iron has long been the chief. Whatever its therapeutic value may be, it is certainly used by most physicians in a routine manner, as their fathers or preceptors did before them. The widespread belief that iron does some good in erysipelas seems to be the strongest, if not the only, proof of its efficacy. It is usually given in doses of a half drachm or more, every two or three hours, during the height of the attack, but the modern antipyretics will be found of much more service during this period, and stimulants will be found useful when the fever has abated. Hypodermic injections of pilocarpin (gr. $\frac{1}{6}$) have been successfully used by Da Costa. The profuse sweating induced by the drug lessens the patient's temperature, and seems to check the further development of the inflammation.

In the local treatment of erysipelas the source of infection should be sought for, and in case of any wound or abscess this should be treated surgically in accordance with approved antiseptic methods. When the face is the seat of disease the nasal cavity should be carefully examined, all crusts removed, and an antiseptic spray used frequently.

Various applications have been highly commended for their therapeutic virtues, but the reputation of many of them has doubtless been based upon the fact that the disease generally terminates favorably whatever may be applied to the surface.

The attempts made to check the peripheral extension of the inflammation by painting the healthy skin with tincture of iodine, nitrate of silver, or carbolic acid have often failed, and in many cases have done positive harm by increasing

the inflammatory process. Collodion or strips of adhesive plaster applied just beyond the margin of the erysipelatous patch are more likely to confine the disease by diminishing the vascularity of the skin and exerting pressure upon the lymphatic vessels. The scarification of the border of the patch, with subsequent application of a bichloride dressing, and the injection of carbolic acid at the periphery, have been strongly urged, but these are somewhat heroic methods of treatment, and apparently not superior to the simpler measures already mentioned.

To the swollen, reddened, and painful surface ichthyol, creolin, tannin, iodine, iodoform, and many other applications in the form of powder, lotion, and ointment have been highly praised. Ichthyol in particular has been strongly advocated in recent years in cases of erysipelas, as in many other skin diseases. It may be used with water, oil, or collodion, and of a strength varying from ten to fifty per cent. Creolin has been used by Koch, white lead by Barwell, zinc paint by Blackader, picric acid by Tassi, and various similar remedies by various eminent therapeutists. Duckworth has called attention to chalk ointment, a favorite remedy in the erysipelas wards of Saint Bartholomew's Hospital. It is made of prepared chalk and lard in equal proportions. The precipitated carbonate of lime is equally serviceable and makes a whiter ointment. Patients are said to experience a feeling of relief from this application, and to prefer it to others which may have previously been used. It does not get in the eyes, as does flour when freely dusted over the erysipelatous surface, and is superior to white paint, which at times causes considerable pain. The ointment may be renewed twice or oftener in twenty-four hours.

Most of these applications are apt to make the patient look worse, sometimes make him feel worse, and never exert any notable curative result in spite of the fact that the patient gets well. Although the looks of a patient, whose face is doubly disfigured by the disease and its treatment, is not a matter of the first importance, the comfort or discomfort produced by any local application should certainly be taken into consideration. Until it is definitely proven that a certain application tends to abort, modify, or cure the disease, it is

advisable to avoid all such as cause discomfort or unnecessary disfigurement. A five per cent. solution of sodium salicylate, as recommended by Besnier and Hallopeau, or a weak bichloride solution is certainly a less objectionable dressing, and, doubtless, quite as effective as those already mentioned.

According to my experience, a ten per cent. solution of sodium hypophosphite or a saturated solution of boric acid in rose water, applied frequently by means of cloths or light compresses, will prove most agreeable to the patient, and accomplish all that can be expected from local treatment.

As the disease is an infectious one, the complete isolation of the patient is imperative, and especially when the disease occurs in a hospital ward. A large and well-ventilated room is desirable, and the physician in charge should take every precaution in the shape of cleanliness and disinfection to prevent the conveyance of the disease to some other and perhaps remote patient.

Recurrent attacks of erysipelas can sometimes be avoided by treatment of the nose and throat, since a catarrhal condition with slight ulceration of the mucous membrane of this region tends to invite an attack. Many cases, however, of so-called recurrent erysipelas are simply a local dermatitis with considerable œdema, and may arise from various causes.

ERYTHEMA

Erythema, or simple congestion of the skin, occurs as the result of a variety of causes, both internal and external. It appears usually in the form of red macules, or patches of varying size and shape. Sometimes a large extent of surface is involved, and an epidermic desquamation may follow the eruption, as it does in scarlatina. The patches of simple erythema are not raised above the surface of the normal skin as a rule, and usually assume a dull hue before they disappear.

Erythema, like dermatitis, may result from injury, heat, cold, or contact with poisonous substances. In many cases it is difficult to determine whether there is a simple hyperæmia or an inflammation of the skin present, and the precise diagnosis is a matter of no very great importance.*

In one common form of erythema, known as intertrigo (erythema intertrigo), a redness of the skin results from pressure and friction of opposing surfaces. This is often noted about the genitals and neck of fat infants, and sometimes beneath the pendulous breasts of women. From heat and irritation of the sweat in hot weather the hyperæmia often passes into an inflammatory condition with maceration of the epidermis, and in some cases pronounced eczematous symptoms develop.

The treatment of erythema consists mainly in removing the exciting cause, whether this be some external irritant or an error of diet. If it seems necessary, a cooling or soothing application may be made to the skin. In mild cases a greasy ointment is more uncomfortable than the eruption itself, and a dusting powder or lotion is far preferable, although even this may be quite superfluous.

Many complicated powders have been recommended in the text-books, but powdered starch or talcum is practically as efficient as any. Before using any powder, the skin should be gently bathed with cool water and carefully dried, and any tight or ill-fitting undergarment cast aside. Should there be a burning sensation present, a lotion of zinc oxide in lime water or a saturated solution of boric acid may be used to advantage.

In the intertrigo about the genitals of infants it is important to have the napkins changed as soon as they are wet, since the persistence of the disease is often due to the irritation of the urine. Much stress is laid upon this point by every writer, but another of even greater importance is rarely mentioned in the text-books. A partial phimosis often exists in male infants, which causes a retention within the prepuce of a portion of the urine voided. This dribbles slowly after the napkin has been changed, and tends to keep the scrotum and surrounding parts moist and irritated. In every such case the physician should make a forcible retraction of the prepuce, if it is necessary, and carefully instruct the mother or nurse to do the same after each passage of urine, and before the dry napkin is applied. Attention to this point will often effect a speedy cure of an intertrigo which has long persisted in spite of dry napkins and a useless variety of powders.

ERYTHEMA MULTIFORME

Multiform erythema is a name applied to a distinct affection of the skin in which there is a marked exudation into the cutaneous tissue which tends to raise the red disks or patches considerably above the level of the surrounding skin. It includes not only the papular, annular, and marginate forms of exudative erythema, but those bullous and nodular eruptions which are described by some writers as separate diseases under the names of herpes iris and erythema nodosum.

The cause of multiform erythema is obscure, and owing to its sudden and often unexpected onset, and to its tendency to run a definite course, which is scarcely modified by treatment, it has been regarded by some as closely allied to the acute exanthemata. The eruption occurs in both sexes and at all ages, although in youth it is especially common. Its relation to rheumatism and malaria is claimed by some writers, but Crocker, who is strongly of the opinion that the rheumatic and gouty are particularly liable to the disease, is compelled to state that, in a large number of cases, no irritating or exciting cause can be discovered.

The disease is of most frequent occurrence in the spring and autumn, and seems prone to attack those who have just landed from ocean steamers. In our large clinics in New York the occurrence of the disease among immigrants has frequently been noted, and sometimes ascribed to a complete change of diet. But as the first-cabin as well as steerage passengers are sometimes affected, it seems improbable that any dietetic origin can exist, and I am more inclined to attribute its occurrence to the sudden changes of temperature which are not uncommon in this region. Crocker cites cases in which exposure to cold, heat, or wind would evoke an attack of the papular type.

The treatment of erythema multiforme is unlikely to influence the course of the disease in any notable degree—although it may frequently tend to make the patient more comfortable. Kaposi claims that we are unable to prevent the first eruption or subsequent relapses, or to accelerate the involution of the lesions, and that treatment is therefore superfluous.

When rheumatism, gout, or anæmia are present, sodium salicylate, potassium iodide, or some preparation of iron may do the patient good, and indirectly benefit the eruption. The iodide of potassium has been highly recommended by Villemin in ten-grain doses, three times daily, but it is well to remember that this remedy, like arsenic, is double-edged, and if it fails to benefit the eruption, is very likely to aggravate it, especially when continued for some time. As in most of the inflammatory diseases of the skin, the alkaline diuretics, such as the citrate or acetate of potassium, will prove of service in stimulating the kidneys, and thereby lessening the intense hyperæmia of the skin.

Locally, a simple dusting powder or, if there is much burning or itching of the skin, a zinc lotion may be used. When an urticarial condition of the eruption is present, and the burning sensation is intense and annoying, the following lotions are of value, but should not be applied except to an unbroken skin.

℞	Acidi hydrocyanici diluti	℥ ii	3
	Chloralis	℥ i	2
	Spiritus myrciæ	℥ xiv	20
	Emulsi amygdalæ amaræ	ad ℥ viii	ad 100
℥			
			(ATKINSON)

℞	Acidi hydrocyanici diluti	℥ i	3
	Bismuthi subnitratæ	℥ ii	5
	Aquæ aurantii florum	ad ℥ iv	ad 100
℥			
			(VAN HARLINGEN)

To smear a greasy ointment on the skin, as is too frequently done, is of no avail, and is apt to be disagreeable to most refined patients.

In severe cases of erythema nodosum rest in bed is desirable, and a lead lotion may be applied frequently to the painful nodules, either hot or cold as may seem more grateful to the patient. Meanwhile the general condition of the patient may be improved by iron, bitter tonics, and nutritious food, and a return of the disease prevented.

FAVUS

Since favus is a purely local disease of external origin, it is evident that local treatment is alone required for its cure. It is claimed by some writers that certain favorable conditions of soil are essential to its development, but, so far as my observation goes, it will thrive upon the healthiest skin when once implanted. Filth and neglect will naturally favor its rapid growth, and does so with the great majority of poor children who constitute the bulk of cases seen in our city clinics. But no constitutional condition predisposes to its attack. If a strumous or poorly nourished child happens to be a victim of favus, cod-liver oil and iron will doubtless do the patient good, but it can have no effect in modifying the course or chronicity of the disease.

The removal of the crusts is the first step in the treatment of a case. While it is always more convenient to treat a patient with short hair, the barber's shears are not necessarily called for in the case of women or girls with long and fine hair. The preliminary oiling or poulticing of the head, recommended by most writers, for the purpose of softening the crusts, is quite unnecessary. The parasiticide lotion or ointment which is selected for use will soon soften and remove them while exerting the antiparasitic action for which it is mainly prescribed.

Among the many parasiticide remedies which have been highly recommended and successfully employed in the treatment of favus, it matters little whether tar, sulphur, mercury, carbolic acid, salicylic acid, or some other be used. Any one will do the work if it is only given a fair chance to reach the spores of the achorion, which are the cause of the disease. Shampooing and epilation are therapeutic measures which are usually of far more importance than the choice of a parasiticide, and the neglect of these leads often to disappointment and failure. The oil of cade, firmly rubbed into the scalp, is useful at the outset, as it readily removes the crusts, and, although not a powerful parasiticide, may suffice to effect a cure in some cases. Corlett recommends the use of one drachm of carbolic acid in four ounces of glycerin. When crusts are removed, a lotion of bichloride of mercury in alcohol, of one per

cent. strength (five grains to the ounce), may be cautiously used upon a small patch, but such a lotion should be diluted with from one to five parts of water when applied to a large surface of the scalp.

The head of a child with favus should be shampooed (not merely rubbed, but scrubbed) with soap every day. Many physicians rely wholly upon the effect of an antiparasitic ointment, and are surprised because it fails to cure. Others give proper directions to have the head washed, never think of the matter again, and are amazed at the obstinacy of the disease. It is the duty of the physician in charge, not only to order a daily shampoo, but to see that his directions are faithfully and properly carried out. When the shampooing is properly done, the antiparasitic remedy, whatever it may be, is greatly increased in efficacy, and the duration of treatment much shortened.

Epilation is of particular value in chronic cases of favus. The more chronic the case, the more imperative is the necessity for thorough and repeated epilation of the affected patches. Many methods of pulling out the hair have been devised and practised in the past, some of them, like the Burgundy pitch skull cap, scarcely more agreeable than methods of extracting confessions of guilt employed in the Inquisition. Years ago I used cylindrical sticks composed of resin, wax, and balsam of Peru for the purpose of epilation, but they failed to take the place of forceps. If too much wax is used, the stick becomes too soft to hold on to the hairs when the end is melted in a flame; and if too much resin is used, the heated end of the epilating stick is likely to burn the child's head. When hairs are long and loose they can be pulled out by the fingers, which is simpler than Kaposi's method of grasping the hairs between the thumb and a spatula. When the hairs are short, as they must be after repeated epilation, light forceps with broad blades will be found of great service.

For favus of non-hairy parts, the same treatment may be employed, and a cure effected in far less time than in case of favus of the scalp. The latter is always an obstinate affection, and under the most favorable conditions a chronic case may demand months of vigorous treatment. Even when apparently cured, the patient should be kept under observation and a frequent examination of the scalp made in order to detect the first indication of a relapse.

FIBROMA

FIBROMA is a connective-tissue neoplasm which may form one or many nodular, pouch-like, or pendulous tumors of the skin. It has been called molluscum pendulum, molluscum fibrosum, and fibroma molluscum. A very simple form, to which the names acrochordon and fibroma filiforme have been applied, consists of a small thread-like excrescence, a few lines in length, which is most commonly seen upon the neck of middle-aged or elderly women. These are usually multiple and sometimes quite numerous. They give rise to no annoyance, although they may be considered undesirable by those who prefer to have a normally smooth skin.

Another common form of fibroma is the firm, rounded tumor which frequently develops upon the face in adult life, and is commonly spoken of as a mole (*nævus fibrosus*). When small these are of the color of the surrounding skin, but when they attain the size of a small pea they are apt to be of a dull red hue, and may be slightly constricted at the base.

In most cases of multiple fibroma the tumors are soft and pouch-like, vary in size and density, and frequently cover the greater portion of the body. They may be congenital, but usually develop or increase in number and size in later life. Some of the tumors may be slightly indurated and feel like split peas imbedded in the skin, but the great majority are soft, and pressure with the finger shows that the corium at their base is thinner than elsewhere. Frequently one or more large pendulous tumors may co-exist with hundreds of small tumors, either sessile or pedunculated.

When a broad pendulous tumor forms and appears like a ridge or flap of redundant skin, the disease has been described under the name of dermatolysis or pachydermatocele. This growth differs in no essential respect from the large pedunculated tumors. The skin in some cases appears coarse in texture

and is slightly pigmented, while in others it is atrophied from tension and appears smooth and fine. The periphery of the growth is generally more dense than the included, projecting portion.

The cause of this fibrous growth is unknown. Many patients with multiple fibroma are small, poorly developed, and weak, and the disease may occur in successive generations.

The treatment of fibroma consists solely in the removal of the tumors. The small filiform excrescences so common upon the neck, or longer ones which may develop on the back or in the axilla, can be best treated by means of sharp, curved scissors. It is advisable to first seize the growth with a pair of delicate forceps and make gentle traction in order to remove it entirely and yet without injury to the adjacent skin. The slight hemorrhage, which is sometimes rather persistent, can be readily checked by touching the cut surface with a stick of nitrate of silver.

The firm, rounded fibroma so often occurring upon the face can be best treated by means of an electrolytic needle. This should transfix the growth in the direction of the cleavage lines of the skin, being introduced at one or more points according to the size of the tumor. This method of treatment will cause the growth to shrivel, and perhaps become necrotic. In the latter case the blackish crust which forms will usually fall in a week or ten days. In using electrolysis for a fibrous mole upon the face of a girl or a woman, it is well to bear in mind that it is far better to destroy too little than too much tissue. In the former case the operation can be repeated, while in the latter case a depressed scar or pit is apt to be left, to the dissatisfaction of the patient and the discredit of the operator.

In cases of multiple soft fibroma the tumors may be excised when they are few in number or situated so as to become inflamed by the friction of the clothing. When numerous, their successive ablation is rarely desired by the patient. The large flaccid tumors or rolls of skin seen in cases of fibroma pendulum (dermatolysis) may be removed by the knife or galvano-cautery, but these growths are extremely vascular, and when they involve the head, an operation is usually a serious matter.

FURUNCULUS

A furuncle, or boil, is an acute phlegmonous nodule involving the skin around one or more follicles, and terminating in necrosis of its central portion. It begins as a painful induration, rapidly forms a rounded or conical, reddened tumor, and usually presents a yellowish point or follicular depression at the summit. After several days of throbbing pain, suppuration takes place, and the core of the boil, a whitish necrotic mass, is evacuated.

A furuncle may occur singly, or a number appear at the same time, and in many cases successive crops of boils keep the patient in misery for months or years, if proper treatment is not instituted. They occur upon various parts of the body, but most frequently upon the neck, shoulders, buttocks, and hands.

The etiology of furunculus is a most interesting subject, and though it has been carefully studied, there still remain some unsettled problems. That a boil is of a parasitic nature, and directly due to the presence in the skin of a microörganism (usually the *staphylococcus aureus*), is generally admitted, but there is much said and written concerning a furuncular diathesis or predisposition on the part of the patient, which is much easier to claim than to substantiate. Diabetic patients seem to be especially prone to suffer from boils and carbuncles, and the reason for this has never been satisfactorily explained. A relationship of boils to gout, chronic disorders of the digestive system, and disturbances of menstruation has been claimed, but it is very doubtful whether the assertion of such a relationship can be supported by facts. As to sewer gas and arsenical wall papers being causative factors in furunculosis, the idea seems scarcely more absurd than would the assertion that they cause pediculosis.

When boils occur in Bright's disease, tuberculosis, and convalescence from various fevers, it is not because the skin has undergone any pathological change which renders it a more favorable soil, but because ordinary ablution has perhaps been neglected, and through the favoring influence of local heat and moisture the furuncular germs have found their way into the follicles.

The disease is one of external origin, and is contagious. This accounts for its frequent occurrence in damp and crowded buildings, and for its occasional epidemic form. The fact that it occurs frequently in perfectly healthy subjects, and with especial frequency among boat crews (as contagious impetigo does among football players), points to its entire independence of any general disorder of nutrition or any local condition other than that which exists in the normal skin. I cannot agree with Jamieson, who states in his admirable work on Skin Diseases that a well-recognized cause of boils is found in the regimen pursued by those training for boat-racing or pugilists. He says that the more out of condition they are before going into training, and the harder they train, the greater the liability to boils, or, expressed otherwise, the more sudden the change. This is attributed to a rapid alteration in the condition of the blood and tissues, due both to the variation in dietary and the increased metamorphosis of tissue from exercise. The fact that the oarsmen's hands are most frequently the seat of the boils is more readily explained by the hypothesis of microbes on the oar handles. In short, the favorable soil which is mentioned by so many writers has little or nothing to do with the diet or the general health, but results simply from a lack of absolute cleanliness.

The treatment of a furuncle is much simplified by this view of its etiology. Internal treatment can have no direct effect upon the disease. Yeast, the remedy to which so many have pinned their faith in past years, and in which I used to be a firm believer, must be discarded as a therapeutic delusion. Arsenic, that much-abused remedy, which sometimes does good in other skin diseases, cannot possibly do anything but harm in this disease. Sulphur, which in some one of its forms has been so highly recommended and so faithfully prescribed, must be condemned as having no more value than its internal use in scabies. Even calx sulphurata (sulphide of calcium), which has been almost universally conceded to be of value in all suppurating skin diseases, must be recognized as inadequate to cure a boil. I have long been of the opinion expressed by Hyde, that it is extremely doubtful whether this drug exerts any influence whatever upon furuncles. Hardaway refers

to the laudation of the drug by various therapeutists, and adds that, after using it in a routine way for sixteen years, he is unable to affirm that he has seen any constant or certain effect from it. Allen recommends the internal use of the hyposulphite of sodium in doses of from ten grains to a drachm, given well diluted, in the morning, or in smaller doses repeated during the day. He attributes its beneficial action to its elimination through the glands, but others who have tried the remedy are inclined to believe that this beneficial action is purely hypothetical.

Although internal treatment can neither cure nor directly influence the course of a boil any more than it can affect ringworm or other local skin diseases, it may improve the health of the patient and indirectly lessen the amount of inflammation produced by it. A man in perfect health is as liable to have a boil as one who is weak and debilitated, provided the furuncular germs find access to a follicle, but in the case of the latter the inflammation and suffering resulting from the local infection will naturally be much greater.

The application of iodine, nitrate of silver, or carbolic acid to the surface of the inflamed skin is not likely to do good, and may serve to increase the inflammation, as does that most popular of domestic remedies, "soap and sugar." When a patient with a boil applies for treatment, the microorganisms which cause it are already deep in the skin, and the best method of reaching and destroying them is to introduce a little carbolic acid into the follicular opening around which the boil begins to suppurate within forty-eight hours. If a sharp-pointed wooden toothpick is dipped in pure liquefied carbolic acid, and carefully and repeatedly pressed into the minute pustule or crust which forms at the summit of an incipient boil, it will often succeed in checking its further development. This procedure ought not to cause much pain, as the acid tends to act as a local anæsthetic.

When the boil has developed into a conical pustule on a reddened and indurated base, a small bit of absorbent cotton wrapped tightly around the point of the toothpick will enable one to introduce more acid into the furuncular mass, with the effect of quickly lessening the throbbing pain and causing a decided diminution in its size. Even when a core has formed, the use of the

acid will hasten its expulsion and prove far more beneficial and much less disagreeable to the patient than the ordinary treatment by free incision and poulticing. At this stage it is unnecessary to incise a boil, although there is no great objection to doing so, if it will please either physician or patient. Before the boil is fully "ripe" incision does more harm than good. Piffard says: "A furuncle should never be opened prematurely. The core or slough remains attached by its deeper extremity for some time, and until this is loosened and discharged the boil will not heal. If prematurely opened the pus is discharged, but the core remains attached much longer than if the furuncle were permitted to fully mature." Bidder injects a few drops of a two per cent. aqueous solution of carbolic acid into the border of the indurated furuncle and on the opposite side introduces and empties the syringe. The fluid flows out of the channel produced by the first insertion of the needle and through the central opening, thereby disinfecting the lesion subcutaneously.

The ordinary hot flaxseed poultice, however grateful it may feel when applied, has been the means of multiplying boils in very many cases. By macerating the surrounding skin and smearing it with the inoculable pus from one boil, the poultice naturally tends to the production of a successive crop. If used at all, it should be made with a saturated solution of boric acid, or water containing one or two per cent. of carbolic acid or one-tenth of one per cent. of bichloride of mercury.

After the furuncle has been treated with carbolic acid in the manner above described, a salicylic ointment or paste may be applied in place of a poultice.

In cases where successive crops of boils have appeared, as they frequently do, the disease is termed furunculosis, and there is a prevalent belief that a furuncular diathesis exists; i. e., a systemic condition of which the boils are simply an external manifestation. When this idea is abandoned, together with all internal remedies, and strict attention is paid to external cleanliness and thorough cutaneous disinfection, I believe that few, if any, cases of furunculosis will occur.

HERPES

Herpes is a name applied to a group of vesicles which is most frequently seen upon the lips, and commonly known as a "cold sore." It is often observed in connection with acute affections which are ushered in by chilliness and fever, but may occur independently as a direct result of wet feet and exposure to a draught of air. In some cases the eruption is not limited to the lips, but occurs upon the nose, cheeks, and neck. The prepuce and vulva are also favorite seats of the eruption, and certain individuals are prone to suffer from recurring attacks. The disease runs an acute course, rarely lasting more than three or four days if the affected skin is not irritated in any way.

Herpes, whether occurring upon the face or genitals, is manifestly neurotic in character, and results from reflex irritation, due to some systemic or local condition which is not always discoverable. An acute general catarrhal condition may be the cause of herpes progenitalis as well as of herpes labialis. Local irritation, which is a frequent etiological factor in the case of genital herpes, rarely, if ever, provokes an eruption upon the face. Although the former is frequently the result of venereal excesses and a disregard of strict personal cleanliness, it may occur in men who have never had any venereal disease, and apparently from no local irritation.

The treatment of herpes labialis is of no great importance, as the eruption tends naturally to a speedy cure. Whether any therapeutic measures can hasten this cure, or do more than satisfy the patient's desire for some kind of treatment, is a question not easy to decide. To abort an attack of labial herpes by painting the patch with spirit of camphor, rubbing it with a piece of borax, or applying alcohol, may indeed be possible, as some have claimed, but in my experience the desired result is rarely attained. When the vesicles have formed, the burning sensation may be relieved by a zinc lotion, and, later, the thin crust may be softened by applying a little cold cream.

The following lotion of Leloir may be employed early with a hope of shortening the attack :

℞	Cocainæ hydrochloratis	. . . . .	2
	Resorcini	. . . . .	3
	Alcoholis	. . . . .	ad 100
℥			

In the treatment of genital herpes, cleanliness is of the utmost importance. If the parts are bathed several times daily in warm water (without soap), especially after each urination, the raw surface left by the rupture of the vesicles will usually heal readily, while the powders, washes, pieces of linen, and tufts of cotton so frequently prescribed are quite as liable to irritate as to soothe. When suppuration has taken place, a lotion of boric acid may be used, and a little of the same in form of powder carefully applied. The superficial cauterization of the raw surface with a lotion or pure stick of nitrate of silver is recommended by many, but even the slight pain caused by this application is usually unnecessary.

Brocq advises the following powder :

℞	Zinci oxidi	. . . . .	2
	Hydrargyri chloridi mitis	. . . . .	2
	Bismuthi subnitratis	. . . . .	ad 10
℥			

To prevent attacks of recurrent herpes, it may be advisable to carefully investigate the sexual habits of the patient, and possibly to circumcise a redundant prepuce, but in most cases a strict hygienic regimen that will put the patient in his best physical condition will prove of the greatest service. Schiff and Leistikow have derived benefit from an ointment containing five or ten per cent. of coal tar rubbed upon the genitals two or three times a week. Piffard suggests the systematic application of astringents, tannin, catechu, etc., with a view to toughening the membrane. Monin recommends the cold douche for thirty seconds over the lumbar vertebræ to be given twice a week. Wolff and Duhring strongly advise arsenic, the former continuing its use for six or eight months. Quinine has been found in some cases to control the disposition to relapse.

HYPERIDROSIS

Hyperidrosis, or excessive sweating, may be physiological, and result from active exertion, from an unusually high temperature, or from a combination of both. An excess of perspiration may also be pathological, and occur in connection with tuberculosis, articular rheumatism, malarial and other fevers, and any exhausting disease. Under these circumstances the hyperidrosis is usually universal.

Localized hyperidrosis is a common affection, and one which is of particular interest to the dermatologist. The hands, feet, head, and axillæ are the regions most frequently affected, and when the perspiration is greatly increased in amount, the patient suffers not only from the unpleasant moisture, but from the tenderness of the macerated skin which usually results.

In some cases the hands or feet alone may be affected. Moisture of the hands, at all times disagreeable, frequently interferes with the daily occupation of the patient, especially when this involves the handling of delicate fabrics. Under slight emotional excitement the perspiration is sometimes increased to such an extent that it will drip from the fingers. In severe and chronic cases the palms present a shrivelled appearance, such as may be seen in washer-women, or in a normal hand after a prolonged hot bath.

In hyperidrosis of the feet the stockings are quickly moistened, and in time even the shoe-leather absorbs more or less perspiration, which, undergoing a chemical decomposition, gives rise to a pungent and offensive odor. The skin upon the soles becomes macerated, and often so tender that locomotion is seriously impeded. The epidermis sometimes peels in large flakes, and much walking is liable to produce blisters. Excessive perspiration of the axilla is frequently noted when patients are stripped in the clinic, and is considerably increased by the excitement or embarrassment incident to the occasion.

Hyperidrosis is a purely functional disease of the sweat glands, and results from paralysis of the sympathetic or other disturbance of the nervous centres. Cardiac disease and various neurasthenic conditions seem to predispose to its occurrence, and may be regarded as an indirect cause of the

affection. Many cases of cerebral and spinal disease and tumors pressing upon the sympathetic have apparently given rise to profuse local sweating, but still we find hyperidrosis existing in many cases where no cause whatever can be discovered.

The disease is sometimes unilateral, and due to faulty innervation of the affected region or to a possible neuritis. It has been known to follow severe migraine and zoster gangrænosis. Kaposi mentions a woman with syphilis, the left side of whose face and right side of body were covered with drops of sweat on the slightest emotional excitement, while the rest of the body remained dry.

The treatment of hyperidrosis is more apt to be palliative than curative, since, as has been remarked, the cause of the disease is difficult to remove even when it may be discoverable. An improvement of the patient's physical condition, whenever this is possible (and it is possible in about ninety-nine per cent. of cases), should be the first therapeutic consideration. Systematic cold bathing, which is such an admirable tonic to the general nervous system, and capable of doing so much good in various cutaneous reflex disorders, will often tend to remove the hidden cause of hyperidrosis, in addition to its having a directly beneficial effect upon the skin. Many patients have as great a horror of cold water in the morning as they have of fresh air at night. I have had to argue long with many women and young girls before inducing them to jump into a tub of even cool water upon getting out of bed in the morning. I have rarely found any who could not do it with benefit to themselves, and I have been cordially thanked by scores for the prescription, or rather for my vigorous insistence upon their taking it. Many of my patients, who have given up a strict diet as soon as they were no longer under my care, have continued to take and enjoy the cool bath prescribed, and months or years later have confidentially told me that it had done infinitely more for their health and complexion than all the various medicines which they had taken previous to the adoption of this simple and delightful remedy.

I do not claim that cold bathing will cure hyperidrosis, but if this is insisted upon in the case of those to whom it is a novelty, in spite of their assertions as to a weak heart, a tendency to rheumatism, or a failure to react,

I am certain that it will tend to lessen the excessive perspiration, and certainly constitute an excellent foundation for other therapeutic measures. The use of sea salt or dairy salt will make a bath more stimulating to the skin, and often relieve pruritus, but as a tonic it is the action of the low temperature upon the terminal nerve filaments that is most desirable. Salt to be of any service in a bath must be used in large quantity as recommended by Piffard. The use of tar, carbolic acid, or sulphur soap in connection with the bath will add nothing to its beneficial effect.

The internal treatment of hyperidrosis includes quinine, which would naturally be indicated when any malarial origin of the affection can be justly assumed; iron, the mineral acids, and any remedy which might seem of service regardless of the perspiratory disturbance. Ergot and belladonna have been prescribed for their direct effect upon the functional disorder of the sweat glands, but the most that can be claimed from their use is a temporary effect. The fluid extract of ergot may be given in doses of a half drachm, three times daily, and atropine in doses of $\frac{1}{150}$ to $\frac{1}{60}$ of a grain. Agaracin, $\frac{1}{6}$ of a grain, is highly recommended by Piering. Crocker has found sulphur the best of all internal remedies in his experience, and cites an obstinate case in which, after almost every variety of treatment had been tried in vain, sulphur kept the disease under for twelve months, and then even the sulphur failed to do good. He gives a level teaspoonful of the precipitated sulphur twice a day in milk. When it purges too much, it may be combined with astringents, as in the following formula :

℞	Pulveris crætæ compositæ	. . . . .	3 vi	35
	Pulveris cinnamomi compositæ	. . . . .	3 ii	10
	Sulphuris præcipitati	. . . . .	3 i ad	100
℥				

A teaspoonful to be taken twice a day.

The condition of the digestive apparatus is commonly thought to have little or nothing to do with the disease, yet, according to Hyde, meat should always be largely eliminated from the dietary. Occasional purgatives or laxatives in the form of mineral water, taken early in the morning, have been advised

with a view to increasing the elimination of fluid by the intestines and thereby lessening the cutaneous discharge. The free use of water and other cooling beverages during the hot summer months, so agreeable and beneficial under normal conditions, may be found objectionable and should be restricted when a notable aggravation of the disease is thereby occasioned.

The effect of clothing in producing or increasing a tendency to hyperidrosis is worthy of consideration, and garments which are too warm, too tight, or of too rough texture should be avoided. But the disease occurs upon uncovered parts, and often in the coldest winter months. The necessity for a very frequent change of underclothing scarcely needs to be mentioned.

The local treatment of hyperidrosis has called forth so many remedies that it may be fairly assumed that no single one is of preëminent value. All of the absorbent powders and astringent lotions which have been recommended do a little good, but rarely if ever cure the disease.

For hyperidrosis of the head and hands a lotion is most convenient to use, especially during the day. I have used one to three per cent. of quinine in cologne water with good effect, but would not say that it is better than a one per cent. solution of formalin or naphthol, or lotions of permanganate of potash, sulphate of iron, bichloride of mercury, and other astringents and disinfectants which have been praised.

For hyperidrosis of the axilla a powder is most convenient to use, and the subcarbonate of bismuth or the stearate of zinc will usually act as well as the complicated mixture of several powders to which some have ascribed especial virtue. The skin should be carefully wiped dry with a soft cloth before applying the powder, and the patient made to understand that frequent and vigorous scrubbing with soap and warm water will do more harm than good. The application of extremely hot water will, however, temporarily check the perspiration, and ladies who suffer from axillary hyperidrosis can sometimes attend a dinner party in comfort after holding for a few minutes in each axilla a large ball of absorbent cotton dipped in water as hot as can be borne.

Hyperidrosis of the hands may be treated by the lotions and pow-

ders already mentioned. When the palms are chiefly affected, they may be bathed in a solution of alum or tannin, carefully dried, and a powder composed of salicylic acid and talcum (one to five), or plain boric acid, rubbed frequently between them. In very obstinate cases, painting the palms (or soles) with a five per cent. solution of chromic acid may be tried. Pollitzer says that it always stops the sweating at least for several days and sometimes cures permanently. The application may be made every ten or twelve days, but great care must be exercised lest there be any rhagades, or cracks, in the epidermis, as lymphangitis, with serious consequences, may result.

Faradization, which has been advocated by some writers, can be most conveniently employed in cases of manual hyperidrosis. To be effective it should be repeated every day or two. Meanwhile the following lotion may be used :

℞	Tincturæ belladonnæ	. . . . .	10
	Aquæ cologniensis	. . . . .	ad 100
℥			

Hyperidrosis of the feet is the most common and unpleasant form of the disease, since in this region the decomposition of the sweat is most likely to be accompanied by a fetid and disgusting odor (bromidrosis). In many individuals, perspiration of the feet is not agreeable to the olfactories even before putrefaction takes place ; but when the fluid is swarming with bacteria the affected person is almost banished from human society.

In mild cases a frequent change of shoes as well as of stockings, and the persistent use of any astringent or disinfectant lotion, or finely powdered alum as an absorbent powder, will prove a simple and efficient method of treatment. On account of the power which boric acid exerts in arresting decomposition, and its freedom from irritating qualities, Thin, of London, advises a change of stockings twice a day, and, when there is any fetid odor, the immersion of the stocking feet for several hours in a jar containing a saturated solution of boric acid. When dried and freed from the bacterium *fœtidum*, which he claims to be the cause of the disagreeable

odor, the stockings may be worn again. He also recommends each patient to provide himself with a half dozen pairs of cork soles, which may be changed daily and soaked in the boric acid solution with the stockings.

In severe forms of the disease the diachylon treatment of Hebra may be employed. Lead plaster and olive oil are melted together and stirred until a smooth mass results. This is spread on pieces of stout linen and plastered smoothly over the feet, which should previously be thoroughly cleansed with soap and water. Lint smeared with the ointment should be introduced between the toes. A light stocking or bandage is now applied. This dressing is to be renewed twice each day, the foot being wiped with a dry cloth, but not washed. The patient may walk about with a loose shoe which does not cover the dorsum of the foot. This treatment is continued one or two weeks, according to the severity of the disease. The diachylon dressing is then superseded by some absorbent powder, and the patient allowed to resume his shoes and stockings. In a few days a brownish-yellow layer of cuticle begins to peel from the affected skin, and a clean, white, healthy surface is exposed. When this layer of cuticle has been completely detached, the foot may be washed and the daily powdering continued. A simpler method is to strap the feet carefully with lead or soap plaster. This may be repeated every three or four days, and often a prompt cure will result.

In the German army the military regulations prescribe a salicylic suet (salicylic acid, two parts ; mutton suet, one hundred parts). A French army surgeon advises washing the feet thoroughly, applying subnitrate of bismuth and renewing frequently without further washing. It is claimed that a cure will often be accomplished in a fortnight.

The question as to possible harm in checking an excess of perspiration has repeatedly been raised, but no case of injury has ever been reported. Even the common fear that a bath taken while perspiring may invite disease or death is entirely groundless, and ranks with the myth respecting the retrocession of cutaneous eruptions.

HYPERTRICHOSIS

HYPERTRICHOSIS is an abnormal growth of hair, whether it be in amount or in locality. It may be congenital, and consist of an unusual hairiness of the whole body, with the exception of the palms, soles, and certain other regions where hair follicles are never present, and tends to increase in later years. It may be localized, as in the case of a hairy mole. Hypertrichosis also occurs as an acquired affection, and may result from local irritation of the skin—e.g., by the continued use of a stimulating plaster—or from some indefinite disorder of nutrition, the origin of which may be looked for in some arrest of development or disturbance of the nervous system. The bearded women on public exhibition, and countless similar cases of less degree in private life, are examples of this latter form and of special interest from a therapeutic point of view.

The causes of hypertrichosis are not usually apparent, and the disease or deformity must be accounted for in most cases by ascribing it to some freak of nature. Occasionally the growth is evidently hereditary, and occurs in several members of a family. In my experience it is vain to seek for any condition or peculiarity common to all patients. Some are in fine physical condition, while others are debilitated. Some are extremely nervous ; some are not so in the slightest degree. Some are stout and some thin. Some are dark and others of light complexion. Some are maidens from sixteen to sixty years of age ; while among those who are married, some have children and some have none. The common idea that the growth of a beard in the female is necessarily associated with masculine traits of character is certainly not founded upon fact, for most of my patients have presented the highest type of feminine refinement. A relationship between facial hypertrichosis and a malformation or

imperfect development of the reproductive organs has been claimed, and doubtless exists in some cases. I have repeatedly noted its connection with deficient menstruation, and seen a growth of hair upon the body diminish after a restoration of a suppressed menstrual flow.

Persistent local irritation, which increases the hyperæmia of any hairy part, may cause hypertrichosis, but the idea which seems to prevail among fashionable ladies, that sea-bathing or the use of vaseline upon the face will occasion an abnormal growth of hair is too fantastic for serious discussion. No proof of the assertion is ever shown, and how such an erroneous idea originated is difficult to imagine.

The treatment of hypertrichosis may be either palliative or radical. Hairs may be pulled out, but, the papilla from which the hair grows not being destroyed, the hair soon grows again. There is a common tradition which is particularly disquieting to ladies with a few hairs upon the chin. It is to the effect that for every hair that is pulled out two will be certain to grow, or that the growth will become thicker and stronger as a result of this procedure. It is a question whether there is any basis for this prevalent belief. It does not explain why the first hairs should grow, and it is certain that when there is any tendency to an increase in the growth, as is frequently the case, new hairs will develop whether any be pulled or not. It is said that the American Indians have tried for many generations to destroy their beards by constant epilation, and have only succeeded in producing a thin, weak growth of hair upon the chin. This lack of success might encourage rather than deter ladies from their attempt to destroy hair by epilation; but, as a matter of fact, the pulling of a few hairs has no effect upon the growth of others in the immediate vicinity unless the skin is kept in an inflamed condition, and the rudimentary hair-bulbs thereby stimulated to an abnormal functional activity. The shaving of the hair has probably no more effect in increasing its growth. Certain ladies are compelled to shave because they have a beard. They do not have the beard as a result of shaving.

When hairs upon a lady's face are few and far between, there is no objection to pulling or cutting them with small curved scissors; but when they are

numerous, this operation involves too much time and trouble, and some depilatory is far preferable. This will remove the hair temporarily and leave the skin smooth and presentable for weeks or months, according to the strength of the growth and its tendency to increase. I have known a light downy growth to be permanently removed by repeated use of a depilatory powder at long intervals. But it is hopeless to attempt the permanent removal of well-developed hairs by the use of any lotion or paste, and the numerous remedies advertised in the daily papers, with brazen assurance, or a guarantee that they will accomplish this purpose, are certain to fail in the production of any result save sore disappointment.

Depilatories, carefully used, are of great value as a palliative measure, especially in the removal of hair from the extremities where its permanent eradication would involve a great amount of time, trouble, and expense. But the unskilful use of a depilatory upon the face will sometimes burn the skin, and leave it red and tender for several days, and its too frequent use may keep up an irritable condition, which will greatly favor an increased growth of hair.

The only method of permanently removing hair which experience has found to be practicable is by the use of electrolysis. This operation originated in America, and during the past twenty years has been adopted by dermatologists in all countries. It was first proposed by Michel, of St. Louis, for the radical cure of trichiasis, and was afterward applied to the facial hirsuties of women by Hardaway. In the performance of this operation it is necessary to have a galvanic battery capable of giving a steady current of from two to five milliamperes, a fine needle, and a suitable needle holder, which is to be attached to the negative cord of the battery. A sponge electrode attached to the positive cord may be applied to the palm of the hand by the patient after the needle has been inserted in the follicle. The current generated by the battery does not destroy the hair papilla by means of heat, but through a chemical decomposition of the fluid contained in the cutaneous tissues. This gives rise to a slight amount of subsequent inflammation and causes a complete destruction of the papilla, or, at least, of its hair-forming function.

The needle which I have used for over twenty years is a delicate, flexible, steel jeweller's brooch. Hardaway prefers a fine irido-platinum needle. For the removal of coarse hairs, as in a case of *nævus pilosus*, an ordinary small cambric needle will answer the purpose. This may be bound to the metal end of the negative cord by a few turns of fine copper wire, the fingers being protected by sliding an inch or more of rubber tubing over the joint. If a special needle-holder is employed, the shorter and lighter it is the better will it serve its purpose. The spring-button electrodes I have found objectionable on account of the suddenness with which they close the circuit and the consequent shock which the patient receives.

A strong light is desirable for the operation. The patient should sit comfortably in a high reclining chair, with the head of the operator on a level with her chin. The needle is now introduced into the follicle, and the success of the operation depends largely upon the skill with which this is done. Good eyesight and a steady hand are as strictly essential as they are in rifle shooting. But many a man, even thus endowed, can never acquire the art of repeatedly hitting a bull's-eye. And many physicians I have found who, after long practice, have failed to acquire the peculiar knack of introducing a needle into the follicle without pricking the skin. Some simply jab it into the skin as near the hair as possible, and thereby give rise to the erroneous impression, held by many, that the operation is a very painful one and likely to leave scars.

When the needle is carefully introduced, the patient, holding the insulated handle of a moistened sponge electrode, may apply this to the palm of the other hand. Gentle traction by means of fine forceps should now be made upon the shaft of the hair until it loosens and can be extracted without force. Before extracting the hair, however, the patient should remove her hand from the sponge in order to avoid the slight shock which is always occasioned by the breaking of the circuit at the negative pole. While an experienced operator can judge of the strength of the current by the effect produced upon the hair follicle, a good galvanometer is almost indispensable in order to properly regulate its strength.

ICHTHYOSIS

Ichthyosis is a congenital deformity of the skin which results in exceptional dryness, cracking of the epidermis, and the formation of scales or horny plates. It may occur in a mild form in which the skin, especially upon the extensor aspect of the extremities, presents a roughened, unwashed, or parchment-like appearance (Xeroderma). This is particularly noticeable in winter, while during the hot summer months the skin may appear perfectly normal.

In a more severe type the rough, dry skin cracks and forms numerous polygonal plates which tend to peel at the margin and present an appearance which has been aptly likened to a tessellated pavement or a serpent's skin. The disease in this form usually affects the face and trunk as well as the extremities, but the flexures of the joints always remain free.

The most severe form occurs in infants who are often stillborn or capable of living but a few days. The skin is greatly thickened and is split into dense, horny plates by deep and painful fissures (Keratoma diffusa). When such an infant survives it presents during its lifetime a most marked type of ichthyosis.

A form of the disease called ichthyosis hystrix is described by all writers, but the cases of this variety which I have seen have been cases of papilloma lineare, a disease having no relation whatever to ordinary ichthyosis. This affection has also been termed ichthyosis linearis neuropathica and nævus unius lateris, on account of the dark papillary excrescences developing in one or numerous lines upon the skin, and usually, though not always, affecting but one side of the body.

In the treatment of ichthyosis, the only internal remedy capable of producing a decided effect upon the skin is pilocarpus (jaborandi). To obtain the desired effect large doses of the fluid extract must be given by the mouth, or the hydrochlorate of pilocarpin injected daily into the skin until a profuse and continued perspiration has softened and removed the

scales. I have seen the skin of an ichthyotic patient become quite smooth under this treatment, but as the concomitant salivation is undesirable and the beneficial effect is not a permanent one, it is better to attain the same end by other and slower means. The internal use of cod-liver oil appears to have a direct action upon the cutaneous glands and tends in time to lessen somewhat the epidermic malformation. The effect of this remedy is far more lasting than that of pilocarpin and hence is greatly to be preferred.

In mild cases a daily warm bath with soap friction and the subsequent inunction of oil or glycerin will serve to keep the skin fairly smooth and prevent a relapse. The Turkish bath may be advisable, although it is not essential, and frequently is not readily procurable.

In severe cases the same treatment may be instituted, but more time will be required to get the skin smooth and soft. Equal parts of lanolin, lard, and limewater make a soft ointment which can be readily rubbed into the skin after the bath, and little, if any, advantage will accrue from the addition of naphthol, resorcin, sulphur, or potassium iodide, each of which has been highly recommended.

In a number of cases in which I have tested the comparative merits of oil and glycerin I have found that the patients, somewhat to my surprise, have invariably preferred the latter. A drachm or two of glycerin may be added to a pint of rain or distilled water, or the following formula used :

R	Glycerini	3
	Sodii boratis	5
	Aquæ rosæ	ad 100
M		

The glycerite of starch is another excellent local remedy, but it should be used very sparingly, as it is apt to leave a sticky condition of the skin which is not at all agreeable.

A mild ichthyosis of childhood is apt to lessen or disappear in later years. Anderson mentions the temporary and even permanent disappearance of the disease after an exanthem such as measles or small-pox.

IMPETIGO CONTAGIOSA

A simple impetigo is described by Duhring and some writers, but the description given applies to few, if any, cases seen in practice which do not properly come under the head of ecthyma, pustular eczema, or contagious impetigo. My own experience leads me to agree with Crocker, who confesses his inability to recognize this disease.

Impetigo contagiosa, or porrigo as it was formerly called, is a distinct affection of the skin characterized by the development of a well-defined lesion, viz., a flattened vesico-pustule which is usually umbilicated and dries into a yellowish crust if not injured by scratching. The lesions are usually discrete, although when numerous and closely aggregated a crusted and excoriated patch may occur. In rare instances the lesions may be papular or bullous.

The disease is common in childhood, but may affect adults, and its contagiousness is evident from the fact that nearly every case can be traced to some other case with which the patient has come in close contact. It has been observed repeatedly among football players, the pustules developing upon the face and hands of those playing opposite each other in practice games, and at points where the skin has accidentally become abraded. In scabies, pediculosis, and other intensely pruritic diseases the lesions of this disease may be very numerous, since, in scratching, the pus from one lesion is very apt to be conveyed by the finger nails and inoculated at many points.

Impetigo contagiosa is undoubtedly of parasitic origin, but the peculiar microörganism which produces it has never been satisfactorily determined. The ordinary staphylococci, streptococci, and other pus-producing germs may be found in the fluid from unruptured vesicles, as in the pus from furuncles and most pustular affections of the skin, but it seems as though there must be some specific germ yet undiscovered which has the property of producing the well-defined and characteristic lesions.

The treatment of contagious impetigo is a local one, as the disease affects

only the skin. The face or other affected parts should be bathed frequently with diluted borolyptol, or water containing a mild antiseptic. A five per cent. ointment of salicylic acid should be rubbed daily upon the crusts, and when raw surfaces are present, the oxide of zinc ointment containing two per cent. of salicylic acid may be used in its place.

The following ointment is frequently used, and Hardaway says of it that, while untreated cases may persist for a long time, the application of this ointment will suffice to effect a cure in a few days.

R Hydrargyri ammoniati gr. x 2
 Unguenti aquæ rosæ ad 3i ad 100

℥

Apply to eruption after removal of crusts.

Crocker remarks that other remedies will also cure it, but the above obeys completely the motto, "Cito, tuto et jucunde."

KELOID

Keloid (or cheloid) is a disease in which one or more firm tumors develop in the skin and manifest a tendency to increase in size by the growth of clawlike processes at the margin. The growth varies in form as well as in size. It may be a small and rounded nodule, or a flattened tumor with a number of depressions upon the surface. In exceptional cases it has appeared in the form of enormous ridges, or elongated tumors. It usually has a smooth, shining surface of a pale red hue, the skin being tightly drawn and often traversed by capillary vessels. The margin is always well defined, and usually rises abruptly from the surrounding skin. There may be slight tenderness on pressure, and in some cases the pain occasioned by the growth is quite severe. Although keloid may occur in any region of the body, the chest and neck are its favorite situation. This has been attributed to the frequency with which the breast is scarred by vesicants and the neck by boils and abscesses.

The course of the disease is slow, though variable. Some tumors

remain for years without apparent change, while others tend to increase by an even peripheral extension or by the growth of the clawlike prolongations. Occasionally a tumor may decrease in size, and even disappear in time, but this termination is likely to involve a question of diagnosis between true keloid and a hypertrophic cicatrix.

The scars of certain ulcers are often raised by the puckering of the skin in the process of healing, and frequently these increase in size and density, and become firm, rounded tumors, bearing a very strong clinical resemblance to keloid. Tumors either rounded or ridged, so often left by acne, sycosis, variola, scrofuloderma, and syphilis, are often called keloid, although they lack the essential features of this disease. Such tumors invariably tend to flatten and to disappear in time, and are quite amenable to treatment. They may be excised and a smooth linear cicatrix left in their place. True keloid has a marked tendency to develop upon a cicatricial base, and this clinical fact tends greatly to complicate the question of diagnosis. Just where the line should be drawn between a simple elevated cicatrix and a scar keloid which has not as yet become painful or sent out any clawlike prolongations into the healthy skin is an extremely difficult matter to decide.

Keloid occurs in both sexes and at any age. In the negro it is notably common as compared with its occurrence in the white race. Its hidden cause appears to be associated with some individual predisposition, of the nature of which we are ignorant. In certain cases a keloidal tumor is certain to develop wherever the skin is cut, pricked, or injured in any way. Many writers have made a distinction between true and false keloid, claiming that the former arises spontaneously and that the latter develops upon an injury to the skin. So far as we know, every keloid may arise from some injury to the skin, although in very many cases it is impossible to get any history of even the prick of a pin or a scratch.

Apparently idiopathic keloid and keloid developing upon a cicatricial base (scar keloid) are one and the same in nature. But every elevated and dense cicatrix is by no means a keloid simply because it may and often does subsequently become the seat of this disease.

The treatment of keloid has always been considered as very unsatisfactory, although some have reported complete success in the treatment of certain cases. If the diagnostic points above mentioned are borne in mind, it is an open question whether true keloid can be cured. In many severe and unmistakable cases, every attempt to remove the tumors by deep and wide excision or by the free use of caustics has failed to accomplish any permanent result. Many of the tumors have shown their disposition to recur even before the wound had healed. In the treatment of several cases which looked very much like keloid and which had been called keloid, I have had most gratifying success both by linear scarification and by electrolysis, but I am not positive that I, or any one else, has ever cured a case of true keloid. The methods of treatment to be mentioned are such as will certainly prove of service in cases of hypertrophic cicatrix or tumors which appear keloidal and which might be properly termed keloidoloid.

Linear scarification, recommended by Vidal in the treatment of lupus and other skin diseases, is of considerable value in reducing the size of the fibrous growth. The parallel cuts seen upon the surface of the skin after use of the scarifying knife or scalpel should be covered with a mercurial plaster, or some caustic application may be applied by means of a soft brush. In a case of reticulated scar tissue upon the face of a young lady whose cheeks looked like waffles, I used the glacial acetic acid subsequent to scarification with a most desirable result after many repeated operations.

Electrolysis is a simpler method of treatment and quite as effective. On account of the density of the tissue a cambric needle should be used in place of the finer ones mentioned in connection with the electrolytic treatment of hypertrichosis. It is to be attached to the negative cord of the battery and should transfix the base of the tumor, making a series of parallel lines through it. A current of five milliamperes or more should be used, and its action will be noted in the speedy whitening of the tissue in the vicinity of the needle. After a number of punctures the tumor may appear larger than ever for a few minutes, but contraction soon takes place, and in a week or ten days it will often be notably smaller. The opera-

tion may now be repeated and the treatment continued for months, or as long as is necessary to bring the growth to a level with the surrounding skin.

Caustics, such as potassa fusa, were formerly in vogue for the destruction of cutaneous tissue, but have been largely supplanted by the electrolytic needle. In keloidal tumors Marie injects a twenty per cent. creosote oil. Leistikow uses a galvano-cautery with fine platinum wire in place of an electrolytic needle, and then covers the tumor with a pyrogallol acid plaster, or the following :

R	Ichthyol	10
	Pyrogallol	10
	Collodii flexilis	ad 100
M		

Thiosinamine, first used by Dr. Hans Hebra in the treatment of lupus and other tuberculous affections, has been highly praised by Tousey, Newton, and others in the treatment of keloid and hypertrophic cicatrices. A ten per cent. solution of the drug in absolute alcohol or sterilized glycerin and water is used, and from ten to fifteen minims may be injected subcutaneously near the fibrous growth, the injections being repeated every two or three days. According to Tousey, a marked effect upon the blood is produced. He found that the number of white blood-cells was reduced within five minutes to a third of the normal amount. They increased again rapidly, and for forty-eight hours there was pronounced leucocytosis.

The injections are attended by considerable pain, and are sometimes followed by a feeling of tension in the keloidal growth or scar tissue. Nausea and vomiting are apt to be occasioned by the injection of larger doses than ten minims, and headache or a drowsy sensation is often produced. Experiments with thiosinamine injections at the Vanderbilt Clinic have not produced any brilliant results, and the mere softening of the tissue reported in several cases might be as readily obtained by some other and less disagreeable method of treatment.

KERATOSIS FOLLICULARIS

This disease has been called *keratosis pilaris* and *lichen pilaris*, but it is a disease of the follicle and not of the hair. It consists of an abnormal desquamation and accumulation of horny cells in the hair follicles which produces an eruption of numerous small, conical, follicular papules of a whitish hue, or of a reddish color when they have become scratched and inflamed. Usually there is little, if any, itching present. The disease is most frequently seen upon the extensor aspect of the arms and thighs, but in some cases the greater part of the trunk may be covered with the lesions. The skin then presents an appearance resembling that temporary physiological condition known as "goose flesh." It is always worse in the winter, when perspiration is lessened. The skin of those affected is apt to be unusually dry, while the eruption itself is harsh and rough and feels almost like a nutmeg grater. When the disease has existed for years, the hairs upon the affected parts are usually broken off close to the skin or entirely absent, and occasionally some may be found coiled up in inflamed follicles beneath the accumulation of horny epidermis.

Under the name of *lichen pilaris*, Crocker describes an affection which seems to me to be a corymbiform variety of *keratosis follicularis*. (See plate.) The epidermic plugs become horny spines projecting above the surface of the skin, and the follicles are usually inflamed. I have observed this eruption upon the upper part of the chest as well as in groups upon the shoulders, but have never noted any symmetrical arrangement of the patches, or seen a patch develop in a night, as it may do according to Crocker's description.

Keratosis follicularis is allied to *ichthyosis*, and is often associated with the latter disease. The same method of treatment is required in either disease to keep the skin soft and in as nearly a normal condition as possible. Hot baths, soap frictions, and the free use of a little glycerin in water or of some very soft emollient ointment will best accomplish this purpose. In severe cases the use of a soap containing both sulphur and sand

is advisable, as mild measures do not suffice to soften and remove the follicular plugs. This may be followed by the inunction of a ten per cent. salicylic acid ointment, or either of the following :

℞	Pulveris pumicis	10
	Sulphuris præcipitati	20
	Saponis mollis	35
	Adipis	ad 100

℥

℞	Naphtholis	10
	Cretæ preparatæ	5
	Adipis lanæ hydrosi	30
	Adipis	30
	Saponis mollis	ad 100

℥

The eruption always has an unwashed appearance, and in some cases may, indeed, be aggravated by neglect of ablutions. In most cases, however, the disease is due to an innate cutaneous disposition, and no amount of scrubbing will remove the unwashed appearance, although it may tend to lessen it.

LENTIGO

Lentigo, a disease commonly known as freckles, consists of small yellowish, brownish, or blackish spots of hyperpigmented skin, which are to be seen upon many faces, especially during the spring and summer. They may also be seen upon the backs of the hands, and even on portions of the body not directly exposed to the sun's rays. The disease is most frequent in youth, and affects those individuals, whether blond or brunette, who do not tan readily and evenly on exposure to the sun. The most marked cases are to be found among mulattoes.

Freckles usually disappear in great part, or wholly, during the winter, and are thus to be distinguished from the pigmentary nævi which frequently appear in the form of small round dots upon the backs of the hands, fore-

arms, or scattered in small number over the body. These latter discolorations are permanent and more frequently observed in later life.

In the treatment of freckles, prophylaxis is of importance, but few ladies are willing to remain indoors or constantly carry a sunshade to prevent the contraction of so harmless a disease. When the dark spots have appeared upon the face in large numbers, the solution of hydrogen dioxide may be used as recommended in the treatment of chloasma. It will tend to lessen, even if it does not wholly remove, the discoloration. The following ointment has been most highly praised and will have some, though often but very little, effect upon the freckles :

℞	Hydrargyri ammoniati	3i	10
	Bismuthi subnitrat̄is	3i	10
	Unguenti aquæ rosæ	3i	ad 100
℥			

Apply at night.

The most efficient method of removing freckles is to apply a minute drop of pure carbolic acid to each dark spot by means of a wooden toothpick or a little cotton wound around the end of a probe. The immediate effect is to whiten the spots, but on the following day, and for several days after, the patient's face will look more spotted than ever. When the freckles are very numerous, a temporary retirement from social functions becomes necessary, and a little unpleasant itching or burning of the face may be endured. But at the end of five or ten days the epidermis destroyed by the acid will have fallen in the shape of thin crusts, the freckles will be gone, and the pinkish hue left in their stead will speedily fade and leave the complexion quite clear. The main objection to this method of treatment is that the freckles may return in a short time upon repeated exposure to the sun.

The plan recommended by Hardaway, of touching each spot with the point of an electrolytic needle, I have tried repeatedly, and though it is well adapted to the treatment of a pigmentary nævus in an adult, I much prefer the carbolic acid in the treatment of freckles.

PLATE XXV.
ELEPHANTIASIS

ELEPHANTIASIS

Elephantiasis is a rare disease in this country, though quite common in certain tropical regions. It is generally regarded as the result of venous or lymphatic obstruction which may be caused by the presence in the vessels of a parasite called the *filaria sanguinis hominis*.

The disease usually affects but one of the lower extremities. The penis and scrotum in males and the vulva in females are also frequently affected and tumors reaching below the knees and of great weight are gradually developed. The surface of the skin may remain smooth, but around the ankle there is often a dark papillomatous growth, suggestive of the bark of a tree.

In some cases the arms, face, or a limited portion of the trunk may become the seat of what is commonly termed elephantiasis, although it is improbable that all cases classed under this head are of the same nature.

The subject of the illustration was an elderly woman who presented herself at the Vanderbilt Clinic and disappeared before a full history of the case was obtained. The legs were symmetrically affected and the chronic œdema had caused marked thickening and induration of the tissues without, however, any notable change in the condition of the skin. Where the swollen legs were in constant apposition below the knees a slight squamous eczema had developed. The patient had suffered from recurrent erysipelatous attacks, each of which had increased the size of the legs. There was no pain nor tenderness and the patient complained only of the difficulty in locomotion.



PLATE XXVI.

EPITHELIOMA

EPITHELIOMA

The accompanying plate shows four illustrations of epithelioma, ranging in severity from a small growth, as easily removed as a simple wart, to a large vegetating tumor, which in many cases causes the patient's death.

In the first illustration the disease appears as a flattened waxy nodule, tending to become depressed and crusted in the centre. In this stage, when the growth might be destroyed by a two-minute operation with the curette, its nature is often unrecognized and it is allowed to gradually increase in size.

In the second illustration is seen a number of waxy nodules with an ulcerated and crusted centre. Under treatment by salves and mild cauterization, which is a most common instance of malpractice, such a growth is often stimulated until it spreads and gradually involves one or both eyes, as seen in the third illustration.

The simple treatment which would have destroyed the disease at the outset is now of no avail, and even thorough excision often fails to arrest its spread. The X-ray treatment which, in the case of small and superficial epithelioma, is merely a waste of time and trouble, I have found to be of great value in the treatment of these cases involving the orbit. It tends to destroy the diseased cells and to promote cicatrization, although it may do more harm than good when used without caution or sufficient experience.

When the disease affects the lip or oral cavity the submaxillary glands are apt to be involved and a large tumor may form, as seen in the illustration.



Copyright, 1905, by G. H. Fox.

EPITHELIOMA.

PLATE XXVII.

EPITHELIOMA RODENS

EPITHELIOMA RODENS

Rodent ulcer is regarded by most writers as a superficial form of epithelioma. The fact that it usually occurs upon the upper portion of the face, is characterized by extensive loss of tissue with very little new growth, and never involves the neighboring glands has led some English surgeons to describe it as a distinct affection.

The disease is rarely painful. It spreads very slowly and may persist for many years without any notable change except in size. In some cases, however, it may develop with greater rapidity and destroy a large portion of the face and neck. Occasionally the rodent ulcer gradually assumes the form of ordinary epithelioma.

In the case of the patient represented in the plate the disease had existed for several years. It had begun in the usual manner with a crusted papule which showed little or no tendency to heal. In fact, it had resisted simple treatment and gradually extended at the margin, which was slightly elevated, indurated, and sharply defined. As a result of caustic applications made by several physicians at various times, a portion of the superficial growth had healed, forming a number of cicatricial islands in a sea of dull red glazed granulations.



Copyright, 1900, by G. H. Fox.

EPITHELIOMA RODENS.

PLATE XXVIII.

ERYSIPELAS

ERYSIPELAS

Erysipelas is an acute inflammation of the skin and subcutaneous tissue accompanied by fever and characterized by redness, pain, tumefaction, and an advancing marginate border. It runs an acute course in about a week and sometimes terminates fatally. It is due to the *streptococcus erysipelatis* or some other specific micro-organism which may find an entrance through some cut or abrasion. In facial erysipelas, the most common form of the disease, the specific germ undoubtedly enters the system through the mucous membrane of the throat or nose.

The disease often begins with a chill and the constitutional symptoms, even in a mild case, are quite marked. A high temperature is very common, and in severe cases, particularly those affecting the scalp, inflammation of the cerebral meninges and various internal organs is apt to ensue.

Acute eczema of the face and the poison ivy eruption are often mistaken for erysipelas, and at the outset the diagnosis is not always evident at first glance, especially as in the latter disease vesicles or bullæ frequently develop upon the red and swollen skin. The high fever, however, and the circumscribed border of the inflamed part will usually lead to a correct diagnosis upon careful observation.

The patient represented in the plate came to the Vanderbilt Clinic after suffering for three or four days. He was very weak and complained of fever and headache. The eruption, as may be seen, presented the abrupt border, and small bullæ were present upon the cheek.



Copyright, 1900, by G. H. Fox.

ERYSIPELAS.

PLATE XXIX.

ERYTHEMA PAPULATUM

ERYTHEMA PAPULATUM

Erythema papulatum is one of the most common forms of erythema multiforme. It presents rounded, elevated and flattened lesions which are at first of a deep red color but gradually become dull and purplish and fade in one or two weeks. The eruption is sometimes accompanied by slight fever at the outset, and the patient usually suffers from an intense burning sensation of the affected skin, especially when it is rubbed or otherwise irritated. The lesions may be found upon various portions of the body but the hands and feet are the favorite site of the eruption. Upon the backs of the hands it is very rarely absent.

In some cases the lesions are hemispherical in form (*E. tuberculatum*) and frequently the flattened papules present a central vesicle (*E. vesiculosum*). More rarely they become the seat of a rapidly developing blister (*E. bullosum*). The disease sometimes designated Herpes iris is simply a vesicular form of exudative erythema occurring generally upon the hands. The lesions are elevated discs with a central vesicle or bulla and a series of concentric whitish rings which may be either smooth or herpetic.

The papular lesions shown in the plate present for the most part a central depression indicating the site of an aborted vesicle. One lesion near the sole suggests the Herpes iris type.



Copyright, 1900, by G. H. Fox.

ERYTHEMA PAPULATUM.

PLATE XXX.

ERYTHEMA ANNULATUM

ERYTHEMA ANNULATUM.

Erythema multiforme is an inflammatory affection characterized by marked exudation into the cutaneous tissue which produces a notable elevation of the various lesions. In this respect it differs from the erythema simplex, arising from either internal or external cause, in which there is merely hyperæmia with very little or no elevation of the lesions.

One of the rarer forms of the exudative erythema occurs in rings and is known as erythema annulatum *vel* circinatum. The lesion begins as a small flattened, bright red disc which gradually increases in size and becomes depressed in the center from absorption of the exudation. A variation in color is then usually noted. The peripheral portion of the disc, being of most recent development, presents the bright red tint of active congestion, while the central portion, even before it becomes depressed, gradually assumes a dull livid hue.

The disease usually runs its course in from one to three weeks, unless it be protracted by the successive outbreak of new lesions. The face and neck is a favorite site, although the lesions may appear upon the trunk and extremities.

The plate represents two rings which have coalesced and formed a patch resembling a figure eight, with a disappearance of the exudation where the raised borders have met. When many rings exist and run together, as they sometimes do upon the trunk, an eruption of fantastic design is usually produced. (E. marginatum, E. gyratum.)



PLATE XXXI.

ERYTHEMA BULLOSUM

ERYTHEMA BULLOSUM

The bullous type of exudative erythema occurs when the attack is sudden and the inflammatory process unusually intense. Its cause is usually difficult to discover, but it has been frequently noted in this country that immigrants, whether crossing the ocean in the cabin or the steerage, are especially prone to suffer from erythema multiforme, and particularly in the spring and fall. The sudden changes of temperature in this climate appear to be more of an etiological factor than any possible change of diet.

The patient represented in the plate was an Irish girl who had been but three weeks in this country. The eruption had begun a week before the photograph was taken, and was chiefly on the face, although the hands were swollen and dotted with rounded papules gradually becoming vesicular and the ankles were slightly affected. Some bullous lesions on the extensor aspect of the forearm presented a red, elevated areola, while others were surrounded by normal skin, like those seen upon the face. The patient had a heavily coated tongue, but claimed to be feeling well in spite of the eruption. Calomel and soda tablets were ordered and in two days the eruption was rapidly disappearing. At this time there were papular lesions upon the backs of the hands with many yellowish crusts and a few excoriated lesions upon the forearms and face.



Copyright, 1900, by G. H. Fox.

ERYTHEMA BULLOSUM.

PLATE XXXII.

ERYTHEMA MULTIFORME

ERYTHEMA MULTIFORME

Erythema multiforme, as the name implies, presents a variety of clinical phases so unlike in appearance that it is not strange that the disease has been described under different names.

The first illustration shows the most common or papular form as it appears upon its favorite location, the back of the hand and forearm. The lesions are smooth, flat red papules or discs, tending to become depressed and darker in the centre and accompanied by a burning rather than an itching sensation.

The second illustration shows a less common form, in which a small bulla develops in the centre of the disc, while the border often presents a vesicular ring (Herpes iris).

The third illustration shows a rarer form of the disease, described as erythema marginatum, in which the discs enlarge, coalesce, and present an irregular scalloped border. It usually is found upon the trunk and resembles urticaria, although the elevated patches are red instead of white and persist for days, instead of hours or minutes, as is usually the case in the latter affection.

The fourth illustration shows a remarkable instance of a rare form of the disease in which concentric circles appear of varying shades of red (Erythema iris). The rings may become vesicular, and in drying form dark annular crusts, as is plainly seen in this patient upon the left of the median line.

The disease in each of these cases ran an acute course, lasting one or more weeks, and was undoubtedly hastened in its course by simple hygienic measures and the use of a soothing lotion.



Copyright, 1905, by G. H. Fox.

ERYTHEMA MULTIFORME.

PLATE XXXIII.

FAVUS

FAVUS

Favus is caused by the growth in the epidermis of a vegetable organism called the achorion. It usually appears upon the scalp but may affect the trunk and extremities. It is characterized by the formation of small, yellowish, cup-shaped crusts, each seated at the mouth of a hair follicle and often perforated by the hair shaft. In chronic cases the accumulation of these crusts, which are at first of a bright yellow hue, forms a thick, friable, pale yellow mass raised considerably above the level of the skin. Upon the scalp the development of the crusts interferes with the growth of hair and in time produces more or less baldness. In many cases a wiry condition of a few sparse hairs growing from a scalp which presents cicatricial depressions is positive evidence of former favus, although the active disease may have been cured for many years.

The disease is far less common in this country than in certain parts of Europe, and is more frequently observed in our seaport cities than in the interior. The disease is usually an imported one (from Poland or elsewhere) and has increased notably within the past twenty years.

The upper illustration shows a boy with favus capitis. The characteristic bright yellow cup-shaped crusts are present.

The lower illustration presents the form called favus corporis (or favus epidermidis). This patient was presented several times at meetings of the New York Dermatological Society. At one clinic he would get nearly well, then stop treatment and in three or six months appear at another clinic with the disease in full bloom.



PLATE XXXIV.

FIBROMA

FIBROMA

Fibroma cutis is a growth of connective tissue which gives rise to tumors of varying size and appearance. These are painless and benignant in character. A very common form of the disease is the small, hemispherical nodule of firm consistence, often seen upon the face and known as *nævus fibrosus*. Multiple fibromata of larger size are commonly found upon the trunk. The smaller tumors are rounded and sessile, but as they increase in size they manifest a tendency to grow pedunculated, and the larger ones, on account of their weight, become pendulous. While some of the smaller tumors present a certain degree of firmness, the larger ones are always flaccid and pouch-like, and pressure with the finger shows that there is a thinning of the corium at the base. Occasionally a pendulous fibroma increases gradually and forms a pyriform tumor of enormous size. Its surface may be smooth and white or appear dotted with enlarged sebaceous glands, with more or less redness of the dependent portion. Sometimes the skin hangs in one or more folds from a broad base, a condition which has been termed *pachydermatocele* and *dermatolysis*.

The negatives taken of the patient shown in the accompanying plate were kindly sent to me by Dr. W. A. Gibson, of Michigan. The man was a laborer and the tumors had been slowly multiplying for many years. Though having no effect upon his general health, their number and size interfered seriously with ordinary manual work.



PLATE XXXV.

HERPES FACIEI

HERPES

Herpes is an affection consisting of vesicles in one or more groups upon an erythematous base. It runs an acute course and while often disappearing in a few days may persist for a week or more, especially when the eruption appears in successive crops.

The affection should be differentiated from zoster, which some writers describe as one of the forms of herpes. Zoster is almost invariably unilateral, occurs in multiple patches which usually follow the course of the cutaneous branches of a sensory nerve, and rarely affects a patient more than once. Herpes, on the other hand, is usually bilateral, frequently occurs as a single small patch, and when multiple, appears independent of any nerve distribution. Moreover, it is especially prone to occur in the form of recurrent attacks.

Herpes is most commonly seen upon the lips but in severe cases it may affect the whole lower portion of the face including the ears and nose. Its outbreak is often attended by a slight degree of fever. It may be noted at the outset of a severe cold or any affection which is liable to be ushered in with a chill. Local irritation in predisposed persons may also evoke the eruption, particularly upon the genitals where it is also common,



Copyright, 1900, by G. H. Fox.

HERPES FACIEI.

PLATE XXXVI.

ICHTHYOSIS

ICHTHYOSIS

Ichthyosis is a congenital deformity rather than a disease of the skin. It is frequently hereditary and is characterized by a notable dryness of the epidermis resulting from a lack of the usual sebaceous and sudoral secretions.

In the mildest form the surface of the skin, especially upon the extremities and in the winter season, may appear mealy or present an appearance suggestive of parchment. In the more common form the epidermis cracks into irregular plates which adhere in the center and curl up at the margins. Frequently these epidermic plates are polygonal in shape and of a dirty hue, giving the surface of the skin a peculiar serpentine appearance.

In the severest form of the disease infants are born with a thickened horny skin, which breaks into large plates. These may become detached, leaving a thin bright red corium beneath. Such infants rarely live.

The illustration shows upon the legs the horny plates of epidermis with peeling edges. Also the roughened and wrinkled condition usually seen about the elbows and knees. The patient, a girl of sixteen, had a brother similarly affected.



Copyright, 1900, by G. H. Fox.

ICHTHYOSIS.

PLATE XXXVII.

IMPETIGO CONTAGIOSA

IMPETIGO CONTAGIOSA

Contagious impetigo is an acute affection characterized by the development of flattened vesico-pustules which usually reach the size of a nickel in about a week, become umbilicated, and finally dry and form yellowish crusts. When these lesions are scratched and irritated, as often happens, dark blood-stained crusts and superficial excoriations are commonly present. If not torn by the finger-nails, the yellowish crusts appear as though they were stuck upon a normal skin, and after falling leave a slightly reddened surface. The disease is most common in childhood, and usually affects the face and hands. More or less itching is always present, and wherever the skin is abraded by the finger-nails the germs of the disease are carried, and at this point a characteristic lesion develops and runs its usual course unless this is modified by scratching or prevented by treatment.

In the accompanying portrait the most typical lesion will be noted below the right angle of the mouth. This has not as yet reached its full size, but shows plainly the depressed center and the vesicular periphery. The other lesions have been scratched and torn by the nails, but still show the superficial character of the eruption. Although some of the lesions have coalesced through proximity, there appears no tendency to the formation of a group or patch, as would be the case in pustular eczema (impetigo simplex), in which disease the crusting is always the result of an aggregation of small pustules, which pour out a yellowish, honey-like exudation.



Copyright, 1900, by G. H. Fox.

IMPETIGO CONTAGIOSA.

PLATE XXXVIII.

KELOID

KELOID

Keloid is a firm elastic tumor of the skin of slow growth and with a notable tendency to recur after excision. It frequently enlarges by the development of one or more processes which bear a slight resemblance to a crab's claw. Hence the name.

Keloid usually develops upon a cicatrix or after some injury to the skin, although in some cases it appears to arise spontaneously. The growth may be single or multiple and of widely varying size and form. It rises abruptly from the healthy skin, presents a smooth surface, of a light pink or purplish hue sometimes traversed by a few fine blood vessels.

Keloid is not likely to be mistaken for any other growth except a hypertrophic cicatrix. This may bear a strong resemblance to true keloid but differs in being painless and in showing no tendency to extend beyond the limits of the scar on which it has developed. Keloidal growths have been observed to disappear spontaneously in young subjects, but generally they enlarge slowly or remain unchanged in size, and often resist all curative measures.

The upper illustration shows a keloid of horseshoe shape upon the female breast, enclosing a cicatricial area. The lower illustration shows a keloid upon the thigh with a claw-like process and outlying nodules.

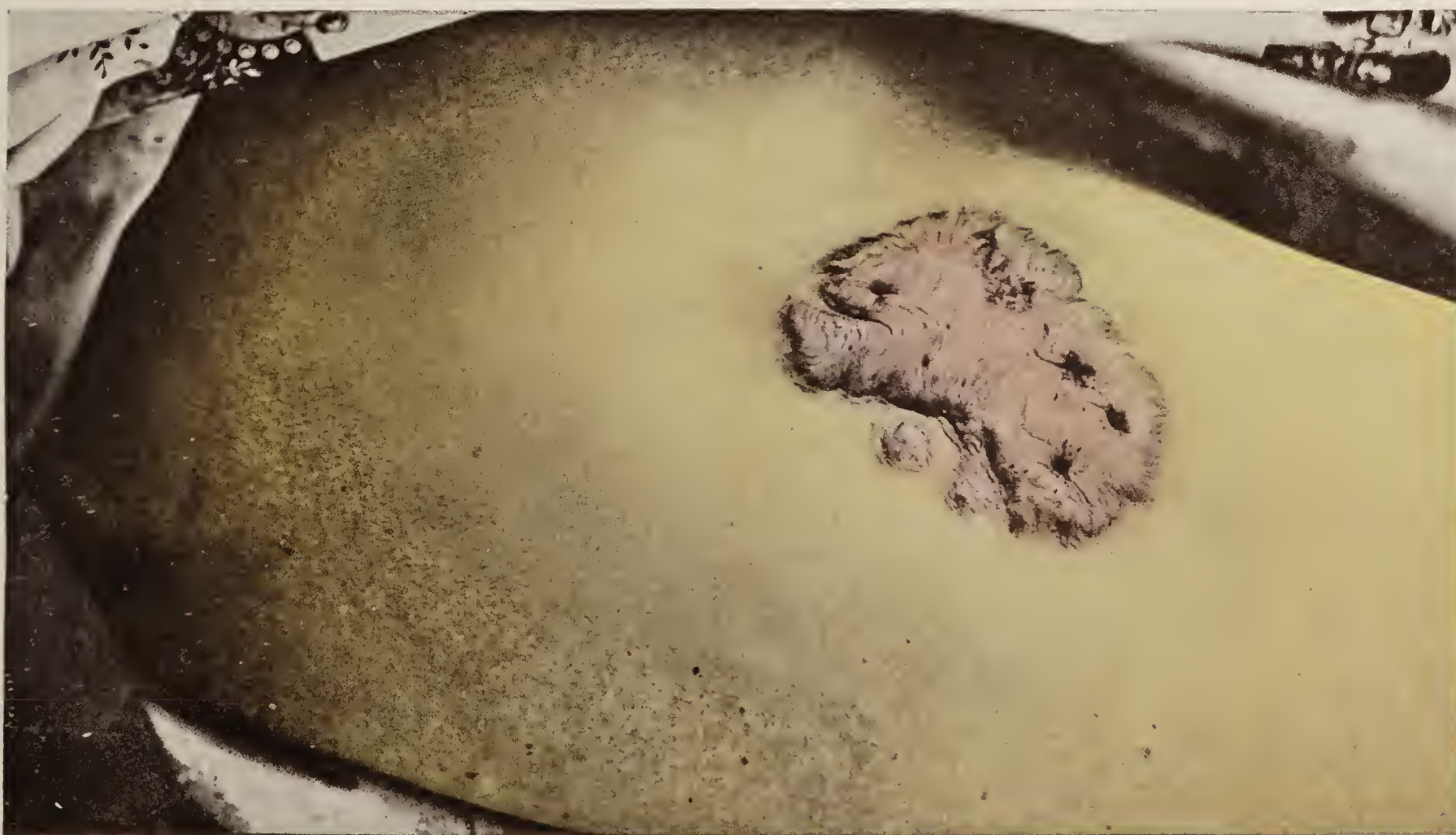


PLATE XXXIX.

KERATOSIS DIFFUSA

KERATOSIS FOLLICULARIS

KERATOSIS.

The term keratosis implies a hypertrophic development of the horny layer of the skin and has been applied to a number of dermatoses varying in nature and in clinical appearance. The condition may be congenital or acquired. In the former case it is allied to ichthyosis and is most apt to affect the hair follicles upon the extensor aspect of the extremities. This condition is not primarily an inflammatory one, but congestion often results from the pressure of the epidermic masses retained in the follicles, and the affected surface is not only harsh and dry, but is dotted with numerous follicular elevations. These conical papules are often of a decidedly horny character and usually of a reddish hue (*lichen pilaris*). Severe itching is at times present, and the use of the finger nails in addition to the choking of the follicles may lead to a partial destruction of the hair.

Localized keratosis is most apt to occur upon the palms and soles. In the congenital form (*tylosis palmæ et plantæ*) the skin of the palmar and plantar surfaces is greatly thickened and presents a smooth horny surface. In the acquired form of keratosis callous patches may occur as the result of pressure, or circumscribed patches may develop spontaneously and usually as the sequel of an inflammatory process.

The subject of the upper illustration presented a somewhat similar condition of the other palm, with a marked hypertrophy and elevation of the free end of the nails. The lower illustration shows an unusual eruption, viz., a follicular keratosis on a woman's forearm, the lesions occurring in a distinct group.



Copyright, 1900, by G. H. Fox.

- I. KERATOSIS DIFFUSA.
- II. KERATOSIS FOLLICULARIS.

PLATE XL.

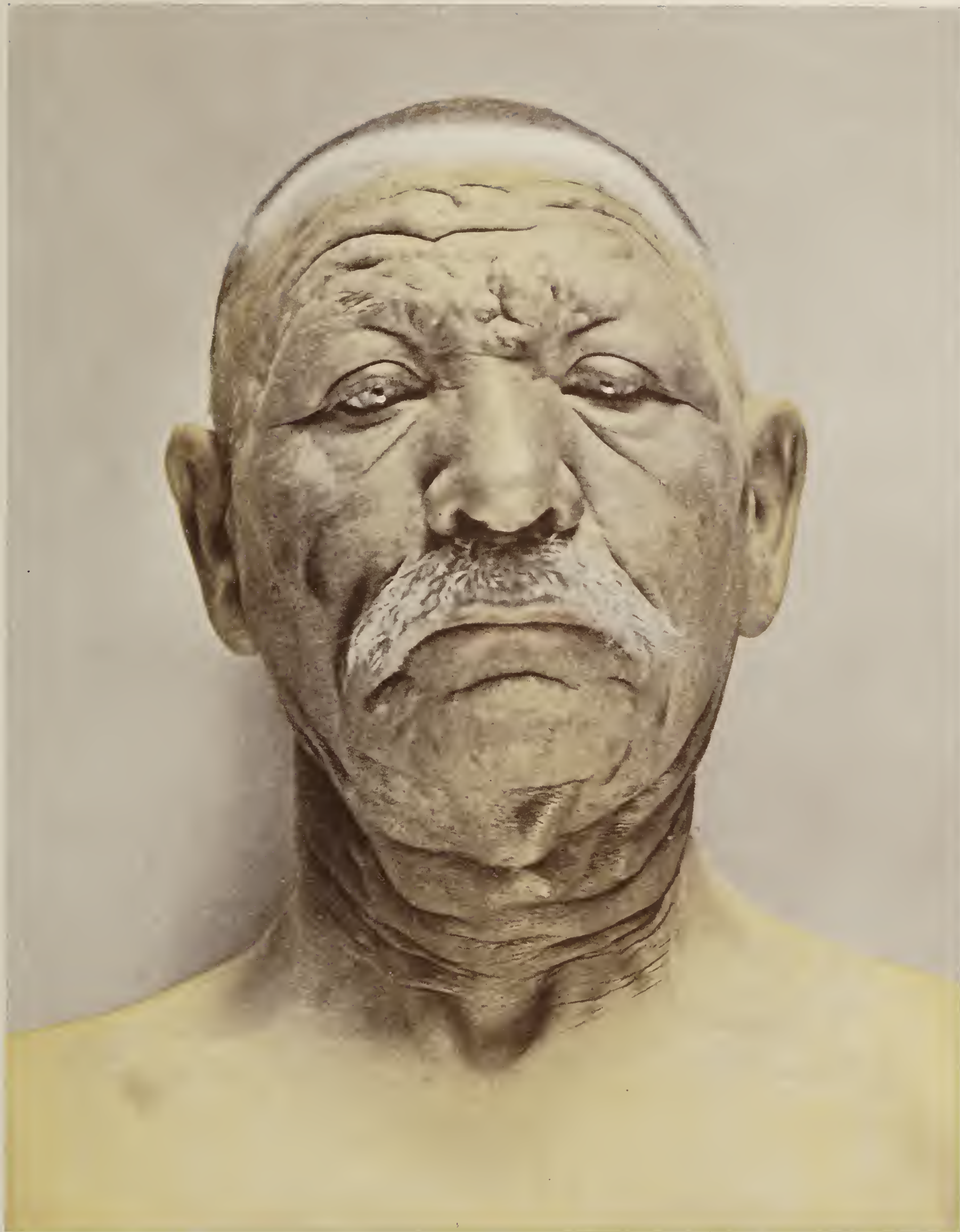
LEPRA

LEPRA

The patient whose face is shown in the accompanying plate was at the Skin and Cancer Hospital for about two years. He was born in Denmark, but spent twenty years in the West Indies, where he undoubtedly contracted the disease, although apparently well when he left there in 1891. A few years later a brownish spot appeared on outer side of left knee, and in 1895 he began to notice small nodules on his forehead. Following this, brownish discs or circles appeared upon the trunk, while both hands and feet became swollen and discolored, with a diminution of cutaneous sensibility. He had lost fifteen pounds during two years previous to entering hospital, was weak and drowsy most of the time, and unable to close his hands firmly.

During his first year in hospital he took chaulmoogra oil at frequent intervals, increasing the dose up to one hundred drops daily, when nausea usually compelled the cessation of its use. Nux vomica was then substituted until the stomach could again tolerate the oil. Under this treatment his general health improved, his strength and weight increased and the lumps upon the forehead and the macules upon the trunk almost disappeared. The nasal obstruction and difficulty in breathing, of which he had complained, was relieved and his eyesight improved to a notable degree. Though not cured he was finally able to leave the hospital and to obtain work as a gardener.

The portrait does not show a marked case of tubercular leprosy with a hideous aspect which would be readily recognizable. It does show, however, the characteristic *facies* which may be noted even in mild cases of the tubercular type of this disease.



Copyright, 1900, by G. H. Fox.

LEPRA.

PLATE XLI.

LICHEN PLANUS

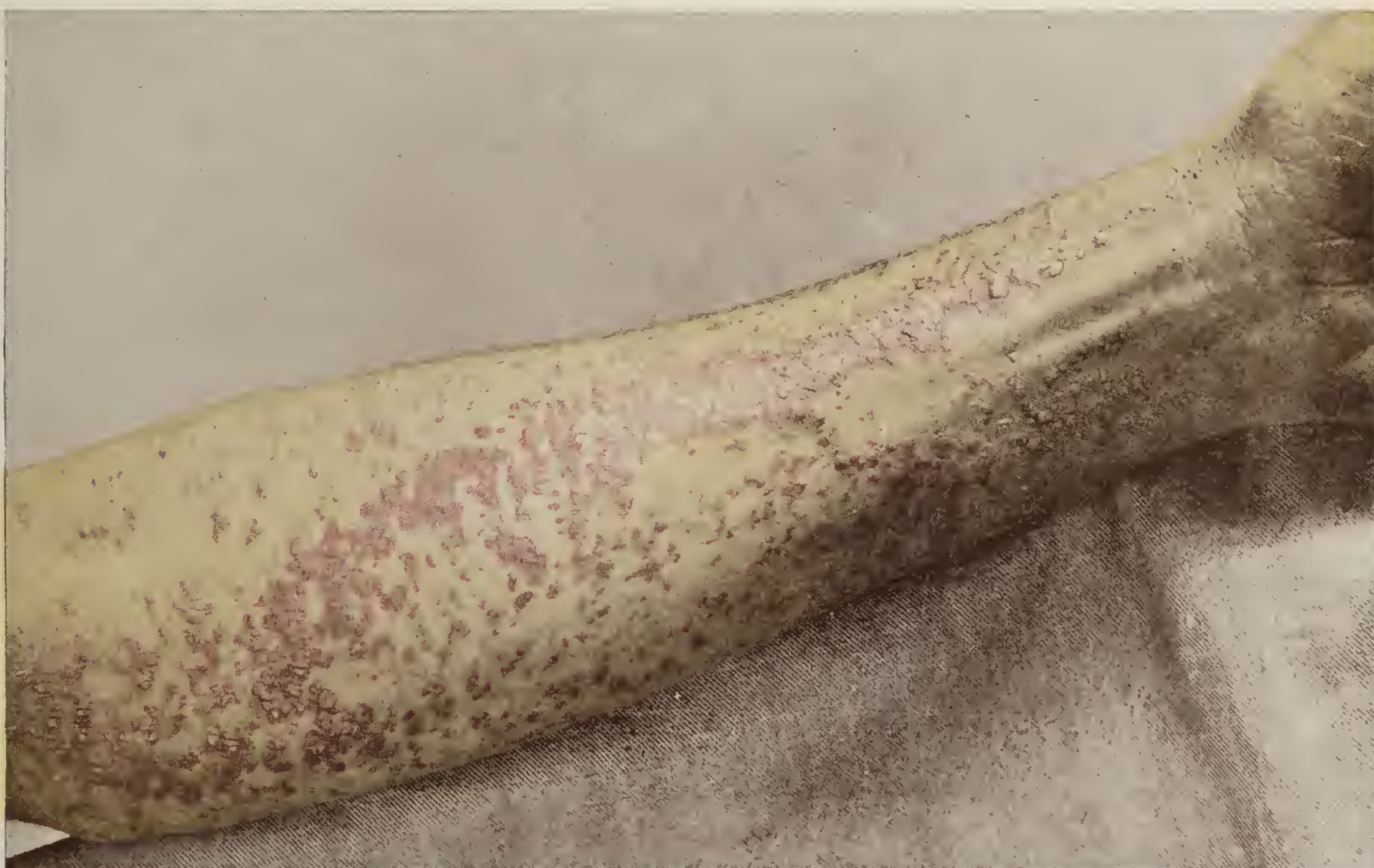
LICHEN PLANUS

Although lichen planus may appear upon various portions of the body, and sometimes present a general eruption, the anterior aspect of the forearm is its most frequent and characteristic site. In some cases the eruption is limited to the forearms, and only in rare cases is this part found to be free.

Upon the woman's arm, shown in the upper illustration, many isolated lesions may be noted, some of which show the characteristic angular outline, flattened glistening summit, and central depression. Near the bend of the elbow the tendency of the lesions to aggregate in small clusters is well shown. The coalescence of such clusters has produced the large patch with the scaly surface which extends along the forearm. The desquamating rings seen upon the wrist are an exceptional feature of lichen planus which is rarely met with and only in cases in which the eruption is abundant and acute.

Upon the man's arm, shown in the lower illustration, the individual lesions are somewhat larger, but show the same tendency to coalescence, and upon the radial aspect where the eruption was of longer duration the characteristic glistening surface of the patch is clearly seen.

The peculiar purplish hue of the eruption in cases of lichen planus is always a striking feature, and as it is rarely met with in other affections, it serves as a very important point in differential diagnosis.



Copyright, 1900, by G. H. Fox.

LICHEN PLANUS.



PLATE XLII.

LICHEN PLANUS HYPERTROPHICUS

lichen planus hypertrophicus

Since lichen planus even in its most typical form is apt to pass unrecognized by the physician with limited dermatological experience, it is not surprising that the unusual forms of the disease must furnish of necessity a severer test of diagnostic skill. Acute general lichen planus is liable to be mistaken for a papular eczema, as many of the lesions may be congested and elevated instead of being flattened and shiny. When covering the entire trunk the eruption may bear a strong resemblance at first glance to a papular syphilide, or on account of its unusual development, it may be regarded as a lichen ruber.

The hypertrophic form of the disease is commonly observed upon the lower extremities and occurs in raised patches. Upon the tibial region these often present a greyish, roughened surface and have a peculiar harsh feeling when rubbed with the finger. About the knee and inner aspect of the thighs the irregular patches are apt to be smoother and of a dull crimson or lilac hue, as seen in the accompanying plate. When of long standing these lesions are usually more or less pigmented, and often the seat of a pruritus which is almost intolerable. As a result of this, the lesions may become excoriated, and therefore bear still less resemblance to ordinary lichen planus.



Copyright, 1900, by G. H. Fox.

LICHEN PLANUS HYPERTROPHICUS.

PLATE XLIII.

LICHEN RUBER PAPULOSUS

LICHEN RUBER PAPULOSUS.

Lichen ruber and pityriasis rubra pilaris are names applied to the same disease. In its first stage the eruption is characterized by numerous small, firm acuminate papules, tending to become tipped with minute whitish scales and to aggregate into large patches. The face and hands at this time are apt to be reddened and stiff and present the appearance of a dry eczema or ichthyosis. The aggregation of the papular lesions produces the squamous form of the disease. The patches may be rounded (like psoriasis) or band-like, especially on the extremities. When the scales have fallen or been rubbed off the infiltrated patches, the skin usually presents a dull red and characteristic rugous appearance.

The patient illustrated in the plate had suffered from repeated exacerbations of the disease, the skin being almost normal at times. The small conical shotty papules are plainly seen about the knee, while upon the inner surface of the thigh it is evident that they have increased in number and coalesced, giving the skin a peculiar dry, leathery appearance. The hand is similarly affected and the dry, scaling surface might be mistaken for a chronic eczema. Upon the thigh, between the thumb and finger, some of the acuminate lesions have become flattened and show a central follicular depression. This resemblance to the lesions of lichen planus has led some writers into the erroneous belief that the two affections are closely related.

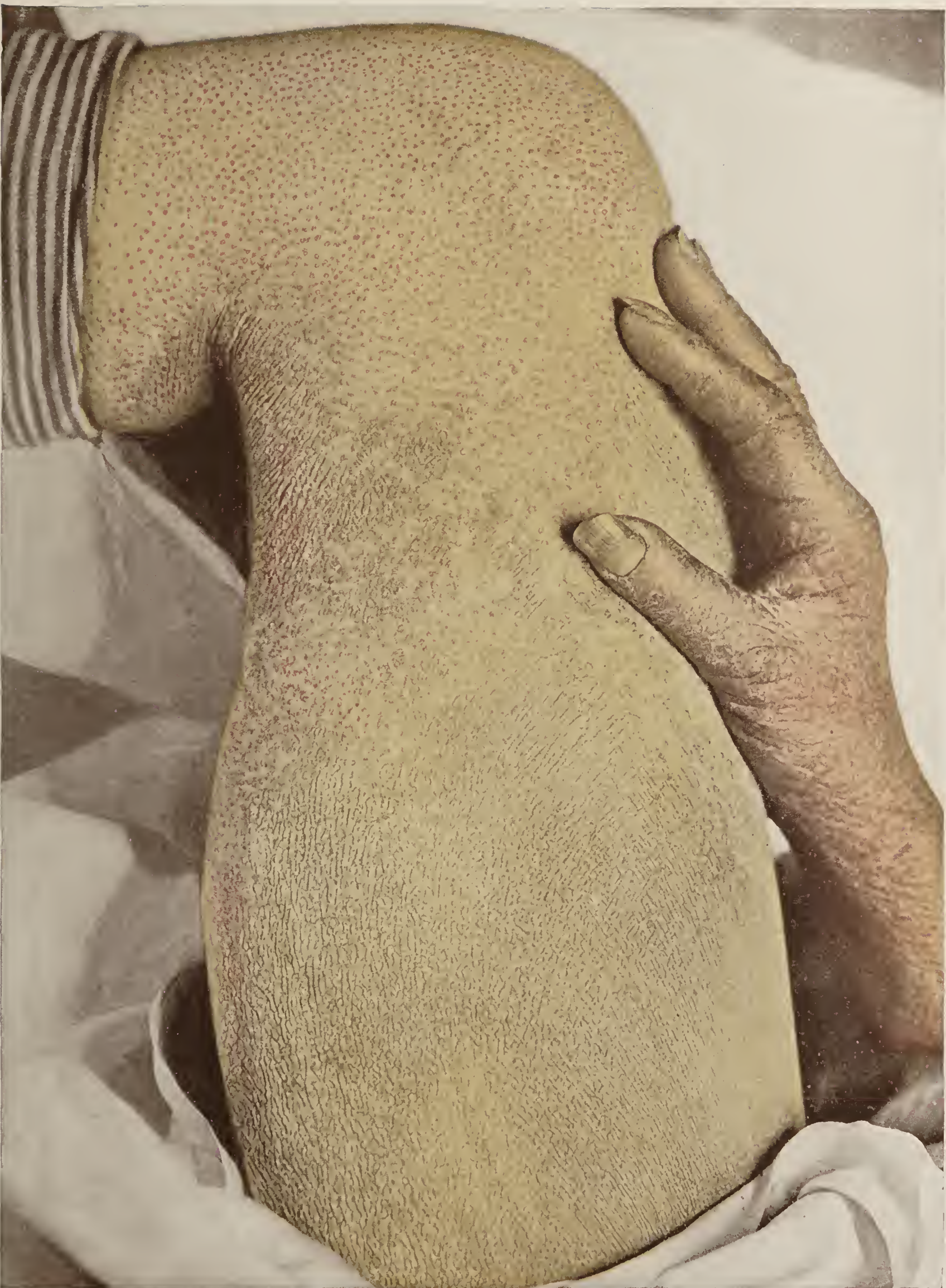


PLATE XLIV.

LICHEN RUBER SQUAMOSUS

lichen ruber squamosus

The squamous form of lichen ruber may simulate psoriasis when scaly discs are present. When the greater part of the body has been affected and the eruption is on the decline ichthyosis is sometimes suggested. The disease is always a chronic one. There is usually noted an alternation of exacerbation and improvement, but the prognosis is always unfavorable.

The accompanying plate shows two clinical forms of lichen ruber, the papular and the squamous, and also the manner in which the former is transformed into the latter by aggregation of the small conical lesions. These papules do not increase in size but by multiplying, especially at the border of a scaly patch, they steadily encroach upon the healthy skin until nothing can be seen but a solid mass of scale-tipped lesions.

The plate also shows the tendency of the scaly patches to assume the form of a long band of varying width and shape, which is extremely characteristic of the disease as Hutchinson has indicated in his description of "Lichen-psoriasis."

Another photograph of this patient, taken several months later, shows the same vertical band, but instead of running over the left hip only, the eruption has now formed a whitish girdle and runs over both hips. The tendency to this localization of the eruption may already be noted in the increased number of papules upon the lower portion of the back where the girdle developed later.



Copyright, 1900, by G. H. Fox.

LICHEN RUBER SQUAMOSUS.

PLATE XLV.

LUPUS ERYTHEMATOSUS

LUPUS ERYTHEMATOSUS

Erythematous lupus has often been called the “butterfly” form of lupus on account of its occasional outline when involving the ridge of the nose and malar regions. In most cases, however, there is no suggestion of this resemblance, and very often this characteristic site of the eruption remains entirely free.

The portrait shows a typical, rounded spot upon the cheek, slightly elevated, and with a dry, harsh, scaly surface. These scales are quite adherent, and when one is forcibly raised the under surface often shows a number of prolongations corresponding to the follicular orifices. The disease is also shown in two very common localities, viz., near the ear and upon the scalp. The crusting seen in the patch upon the auricle is unusual, but the bald spot upon the crown, with its dull red hue and slight roughness of surface, is very typical. Such a patch often serves as a basis of diagnosis in cases where the facial lesions might appear to be of doubtful character.

The cause of erythematous lupus is unknown. The *bacillus tuberculosis* is not found in sections of the affected skin, and there is no kinship between this disease and lupus vulgaris save in the name and an occasional clinical resemblance.

The treatment is, in most cases, notably unsatisfactory. Some recent and superficial patches, unaccompanied by much congestion, will yield to applications of pure carbolic acid, but in cases of long standing, and especially in those of an irritable type, stimulating treatment often does more harm than good. I have seen excellent results follow the internal use of salicylate of sodium.



Copyright, 1900, by G. H. Fox.

LUPUS ERYTHEMATOSUS.

PLATE XLVI.

LUPUS VULGARIS

LUPUS VULGARIS

In the case of the young man who is the subject of this illustration, the disease began at six years of age and has slowly but steadily spread over the neck and a portion of the cheek. The lesions are rather superficial and have shown little tendency to soften and ulcerate. They are most prominent at the advancing border of the patch and some isolated ones enclose areas of normal skin. Where the disease appears to have first developed, patches of wrinkled cicatricial tissue are to be seen dotted with many dull red, flattened tubercles, which are evidently tending towards a spontaneous disappearance.

The patient has always been in fair health, although the indications of a scrofulous taint are manifested in the thickened lips and peculiar doughy skin, and may be discerned in the partial view of the physiognomy revealed in the portrait.

In the treatment of this case a steel burr dipped in carbolic acid was used for a time with good effect, but as the patient did not care to suffer the slight pain involved in this rapid and efficient method, a twenty per cent. salicylic plaster was applied at the Vanderbilt Clinic and during the past few months a notable improvement has taken place. The lesions have ulcerated beneath the plaster, applied successively to small portions of the diseased skin, and a complete cure is expected.



Copyright, 1900, by G. H. Fox.

LUPUS VULGARIS.

PLATE XLVII.

LUPUS SERPIGINOSUS

LUPUS SERPIGINOSUS

Lupus vulgaris commonly attacks the face, the isolated nodules slowly coalescing and forming a raised patch. In exceptional cases, however, it may appear also upon the neck, trunk, and extremities. Though usually a disease of very slow development, it may occasionally run a comparatively acute course, though never spreading with the rapidity which characterizes the development of a tubercular syphilide, to which it often bears a strong clinical resemblance. Although lupus vulgaris usually presents a definite type, there are variations in its clinical appearance which have given rise to various names, such as lupus disseminatus, lupus verrucosus, lupus exedens, lupus serpiginosus, and others.

In the serpiginous form of the disease the nodules coalesce and gradually disappear from the central portion of the patch, either with or without ulceration, and leave a cicatricial area which may be dotted here and there with islands of lupus tissue. The margin of the slowly spreading patch is raised and often covered with crusts, resulting from the softening and ulceration of the peripheral nodules. This form of the disease is very apt to occur upon the neck, especially in strumous or tuberculous subjects, and is more likely to occasion pain, or discomfort, than is lupus of other regions.

In the case of the patient portrayed in the accompanying illustration, aged thirty, the disease began at fifteen, as a group of small reddish nodules. This gradually increased in size, and in ten years involved the greater portion of the neck anteriorly. A patch on the left hand was of eight years' duration, and one on the tip of the nose of subsequent development.



Copyright, 1900, by G. H. Fox.

LUPUS SERPIGINOSUS.

PLATE XLVIII.

LUPUS EXEDENS

LUPUS EXEDENS

Lupus exedens is an uncommon form of ordinary lupus characterized by more or less destruction of tissue with extensive ulceration or deforming cicatrices. It often bears a strong resemblance to epithelioma, and in many cases of a severe type the diagnosis is not readily made without the aid of the microscope. Even with this aid, the exclusion of either diagnosis does not necessarily follow, as it must be borne in mind that an epithelioma sometimes develops upon a patch of long standing lupus, and in such a case is apt to develop with unusual rapidity.

That lupus is closely related to, if not identical with, tuberculosis of the skin is now generally admitted. At the same time the disease often develops spontaneously in children who present no other evidence of tuberculosis, and the inoculation of the skin with tuberculous tissue rarely if ever produces a patch of typical lupus vulgaris.

In the case illustrated the disease had existed for many years. Occasional attempts to cure it had only met with partial success. The deformity of the features is a characteristic result of the ulceration and subsequent cicatrization.





Copyright, 1900, by G. H. Fox.

LUPUS EXEDENS.

